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Attitudes of Staff and Consumers toward Human Rights of Persons with Psychosocial and Mental Disabilities

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1. Title

1.1 Descriptive, cross sectional study, to describe types of attitudes of staff and consumers toward human rights of persons with psychosocial and mental disability, with emphasis on integration into the community; the evidence is from the three main psychiatric hospitals in Khartoum, the capital of Sudan.

1.2 Attitudes of Staff and Consumers toward Human Rights of Persons with Psychosocial and Mental Disability

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1.3 Project details

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Dedication

I would like to dedicate this study to my family: my wife Tayseer, my sons Omer and Ahmed and my daughters Leena and Deema.

Without the commitment and steadfast support provided by my family, I would not have been able to carry out this endeavor. Throughout my professional career, my family has been an abiding and sustaining source of strength, encouragement, and inspiration for which I am eternally grateful.

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To all those who contributed to make this thesis come to light, I am most grateful.

Summary

Background: The new era of Recovery oriented mental health practice is based on human rights and culminating by the convention on the rights of persons with disabilities (CRPD, 2008) and WHO QualityRights ToolKit, 212.

Objectives: This study was designed to address attitudes of staff and consumers toward human rights of persons with psychosocial and mental disabilities and their inclusion into community. Examining staff and consumers' attitudes will highlight deficits in the knowledge regarding the magnitude of this problem and will inform the intended raising of awareness and training in this area.

Methods: A questionnaire was distributed to participants who were 104 staff members (psychologist, psychiatric nurses, social workers and doctors) and 100 consumers at the three main psychiatric hospitals in Sudan. Included in the questionnaire was the Human Rights of persons with psychosocial disability attitude questionnaire (HRQ_6) which was designed by the researcher based on (CRPD) as well as Community Living Attitudes Scale Mental Retardation - Short Form (CLAS), demographic items (for example, age, gender, and marital status) and one question about recovery in mental health. Scores on the HRQ_6 and the 4 CLAS subscales (Empowerment, Similarity, Exclusion, and Sheltering) were reported, and analyses of variance were performed to identify factors associated with each subscale score. The consumers' scores were compared with staff's scores. The HRQ_6 scores were correlated with the 4 CLAS subscales.

Results: Two hundred and four participants from staff and consumers across the three main psychiatric hospitals in Sudan. The participants' of both groups had negative attitudes towards human rights of persons with psychosocial and mental disabilities. Also the participants' attitude scores favored Empowerment and Similarity over Exclusion and Sheltering. Staff and consumers; Men and women; and doctors and other professional groups; responded differently. Previous training on human rights had no impact on the attitude of the staff. There was correlation between the HRQ_6 and the 4 CLAS subscales. The research provided a much-needed window on the process of training and raising awareness with regard to human rights of persons with psychosocial and mental disabilities and their inclusion in to the community.

Conclusion: Staff and consumers hold attitudes toward human rights of persons with psychosocial and mental disabilities that were inconsistent with the recovery oriented mental health practice. More researches are needed to uncover how attitudes towards human rights develop in our community, as well as how training on human rights can influence attitudes.

Sumário

Introdução: A nova era da prática de saúde mental, orientada para a Recuperação, é baseada em direitos humanos, tendo culminado na convenção sobre os direitos das pessoas com deficiência (CRPD, 2008) e no WHO QualityRights ToolKit, 2012.

Objetivos: Este estudo foi concebido para avaliar as atitudes dos profissionais e dos utentes em relação aos direitos humanos das pessoas com doenças mentais e incapacidades psicossociais, e a sua inclusão na comunidade. A avaliação das atitudes dos profissionais e dos utentes irá destacar os défices de conhecimento sobre a amplitude destes problemas e contribuirá para o aumento da consciencialização e capacitação nesta área.

Métodos: Um conjunto de questionários foi distribuído a 104 profissionais (psicólogos, enfermeiros de saúde mental, assistentes sociais e médicos) e 100 utentes, nos três principais hospitais psiquiátricos do Sudão. Este conjunto incluiu um questionário sobre atitudes face aos direitos humanos das pessoas com incapacidade psiquiátrica, HRQ_6 (elaborado pelo autor com base na CRPD), a Escala de Atitudes sobre a Vida Comunitária - Versão Curta (CLAS-Short Form), dados sócio demográficos (ex: idade, gênero e estado civil), e uma questão sobre recuperação em saúde mental. As pontuações na HRQ_6 e as 4 subescalas CLAS (Empowerment, Similarity, Exclusion e Sheltering), são descritos, assim como a análise da variância realizada para identificar fatores associados aos resultados de cada subescala. As pontuações dos utentes foram comparadas com as pontuações dos profissionais e os resultados do HRQ_6 foram correlacionados com as 4 subescalas CLAS.

Resultados: duzentos e quatro participantes, entre profissionais e utentes nos três principais hospitais psiquiátricos do Sudão. Os participantes de ambos os grupos tiveram atitudes negativas em relação aos direitos humanos de pessoas com incapacidades psicossociais e mentais. Adicionalmente, as pontuações sobre as atitudes favoreceram a Capacitação e a Similitude quando comparados com a Exclusão e o Abrigo. As respostas foram diferentes entre os grupos de profissionais e de utentes, homens e mulheres e entre médicos e outros grupos profissionais. A formação prévia em direitos humanos não teve impacto na atitude dos profissionais. Houve correlação entre o HRQ_6 e as 4 subescalas do CLAS. O estudo possibilitou uma visão muito necessária para o processo de capacitação e conscientização em direitos humanos de pessoas com doenças mentais e incapacidades psicossociais, e sua inclusão na comunidade.

Conclusão: os profissionais e os utentes mantêm atitudes em relação aos direitos humanos das pessoas com doenças mentais e incapacidades psicossociais que são incompatíveis com a prática de saúde mental orientada para a recuperação. É necessária mais investigação para descobrir como estas atitudes em relação aos direitos humanos se desenvolvem na nossa comunidade, bem como a forma como a formação sobre direitos humanos pode influenciar as atitudes.

Resumen

Introducción: La nueva era de la práctica de salud mental, orientada a la recuperación, se basa en derechos humanos, culminando en la convención sobre los derechos de las personas con discapacidad (CRPD, 2008) y en el WHO QualityRights ToolKit, 2012.

Objetivos: Este estudio fue concebido para evaluar las actitudes de los profesionales y de los usuarios en relación a los derechos humanos de las personas con enfermedades mentales e incapacidades psicosociales, y su inclusión en la comunidad. La evaluación de las actitudes de los equipos y de los usuarios destacará los déficits de conocimiento sobre la amplitud de estos problemas y contribuirá al aumento de la concientización y capacitación en esta área.

Métodos: Se distribuyó un conjunto de cuestionarios a 104 profesionales (psicólogos, enfermeros de salud mental, asistentes sociales y médicos) y 100 usuarios en los tres principales hospitales psiquiátricos de Sudán. Este conjunto incluyó un cuestionario sobre actitudes frente a los derechos humanos de las personas con discapacidad (por ejemplo, la edad, el género y el estado civil), y la pregunta sobre la recuperación de la calidad de vida en salud mental. Las puntuaciones en la HRQ_6 y las 4 subescalas CLAS (Empowerment, Similarity, Exclusion y Sheltering), se describen, así como el análisis de la varianza realizada para identificar factores asociados a los resultados de cada subescala. Las puntuaciones de los usuarios se compararon con las puntuaciones de los profesionales y los resultados del HRQ_6 se correlacionaron con las 4 subescalas CLAS.

Resultados: doscientos y cuatro participantes, entre profesionales y usuarios en los tres principales hospitales psiquiátricos de Sudán. Los participantes de ambos grupos tuvieron actitudes negativas en relación a los derechos humanos de personas con discapacidades psicosociales y mentales. Adicionalmente, las puntuaciones sobre las actitudes favorecieron la Capacitación y la Similitud cuando comparadas con la Exclusión y el Abrigo. Las respuestas fueron diferentes entre los grupos de profesionales y usuarios, hombres y mujeres y entre médicos y otros grupos profesionales. La formación previa en derechos humanos no tuvo impacto en la actitud de los profesionales. Hubo correlación entre HRQ_6 y las 4 subescalas de CLAS. El estudio posibilitó una visión muy necesaria para el proceso de capacitación y concientización sobre los derechos humanos de personas con enfermedades mentales e incapacidades psicosociales, y su inclusión en la comunidad.

Conclusión: los profesionales y usuarios mantienen actitudes hacia los derechos humanos de las personas con enfermedades mentales e incapacidades psicosociales que son incompatibles con la práctica de salud mental orientada a la recuperación. Es necesaria más investigación para descubrir cómo estas actitudes hacia los derechos humanos se desarrollan en nuestra comunidad, así como la forma en que la formación sobre derechos humanos puede influir en las actitudes.

Attestation

I declare that this work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree. Any views expressed in the dissertation are those of the author.

The dissertation has not been presented to any other university for examination.

Signed: *Abdelaziz Osman*

Abdelaziz Osman

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3. List of Abbreviations

WHO	World Health Organization
UN	United Nations
HR	Human Rights
CRPD	Convention on the Rights of Persons with Disabilities
MH	Mental Health
HRQ_6	Human Rights of persons with psychosocial and mental disabilities attitude Questionnaire
OPD	Outpatients Department
ER	Emergency Room
HMI	History of Mental Illness
CPHMI	Close Person with History of Mental Illness
CLAS	Community Living Attitudes Scale
MANOVA	Multivariate analysis of variance
SPSS	Statistical Package of Social Sciences
WHO-AIMS	World Health Organization Assessment Instrument for Mental Health Systems

1. Part one

1.1. Introduction

Individuals with psychosocial and mental disabilities have long been marginalized. Until now, they are commonly institutionalized, particularly if they suffered from severe type of mental health problems^{1, 2, 3}. Social inclusion is a principle of the Convention on the Rights of Persons with disabilities (CRPD)⁴ and the goal of service providers for people with psychosocial and mental disabilities in many developed countries^{1,2}. However, the practice of social inclusion encounters many barriers in developing countries, one of which is the negative attitudes of mental health care providers (staff) and the consumers themselves toward human rights of persons with psychosocial and mental disabilities^{2,3}. On the other hand, mental health workers and consumers can play an important part in protecting consumer right, raising awareness of the need for better services and influencing policies and legislation to providing concrete help for persons with mental disorders^{1,2}. Efforts to improve mental health must take into account recent developments in the understanding disability and the paradigm shift from the pure classical medical model to the social model of disability⁵. Transformed system that promotes Recovery believes that people can and do recover from mental illness, helps facilitate recovery by providing self-directed services and supports⁵. Treatment in this system is centered around the goals of the person (what is important to the person)^{1, 5}.

In this study we examined the attitude of staff and consumers toward human rights of persons with psychosocial and mental disabilities in the main psychiatric hospitals in Sudan. Insight into staff and consumers' attitudes will serve to highlight areas of training and awareness that could be enhanced to better prepare mental health care providers and consumers to protect human rights of persons with psychosocial disabilities.

We used the community living attitude scale (CLAS) - short form and a questionnaire of attitude toward human rights of persons with psychosocial and mental disabilities based on (CRPD).

Since there was no study addressing the attitude toward human rights of persons with psychosocial disabilities in Sudan, the results of this study were compared with international studies.

Finally, the results and recommendations of this study will be reported to the stakeholders of mental health services in Sudan.

1.2. Literature Review

1.2.1. Sudan in Brief:

Sudan, located in northeast Africa. National name: Jamhuryat as-Sudan. Total area: 1,156,673 sq. mi (1,861,484 sq. km) measures about one-fourth the size of the United States⁶. The current population of Sudan is 40,986,180 as of Tuesday, December 19, 2017, based on the latest United Nations estimates⁷. Sudan population is equivalent to 0.54% of the total world population. Sudan ranks number 35 in the list of countries (and dependencies) by population⁷. The population density in Sudan is 23 per Km² (59 people per mi²). 35% of the population is urban (14,195,253 people in 2017)⁷. The median age in Sudan is 19 years⁷. Live expectancy in Sudan 63.71 years⁶. There are about 19 major ethnic groups and a further 597 subgroups⁸. In 2013, the total adult literacy rate and the female adult literacy rate were estimated at 74.24% and 66.40%, respectively⁹. Its neighbors are Chad and the Central African Republic on the west, Egypt and Libya on the north, Ethiopia and Eritrea on the east, and South Sudan on the south⁶. The Red Sea washes about 500 mi of the eastern coast. It is traversed from north to south by the Nile, all of whose great tributaries are partly or entirely within its borders⁶. Sudan, once the largest and one of the most geographically diverse states in Africa, split into two countries in July 2011 after the people of the south voted for independence after almost 50 years of unrest and a bad civil war¹⁰. Just as Sudan's civil war seemed to be coming to an end, another war intensified in the northwestern Darfur region¹⁰. Many people in the population have been exposed to traumatic events and huge violation of human rights¹¹. Reporting of trauma related problems is very poor¹¹. The users treated in mental health facilities are primarily diagnosed with mood disorders, schizophrenia and other psychotic disorders and anxiety disorders¹². Major health problems in Sudan -apart from mental health problems- include: malaria, measles, tuberculosis, renal failure, malignancies and malnutrition¹³. In areas with poor sanitation to the south and west, water-borne diseases like cholera are a threat¹³. The problems of receiving adequate health care are particularly high in rural regions, which lack trained staff and facilities. However, spending on health is below the 9% level recommended by the World Health Organization (WHO)¹³. Most of Sudan's doctors and medical staff work in the towns/ cities, where the pay is higher. Even so, there are too few doctors – only three for every 10,000 people – and hospitals can be overcrowded¹³.

The vast majority of people with psychological problems and a substantial number of people with physical problems treated by traditional and faith healers due to public believe that illness and in particular mental illness is caused by a supernatural power such as devils, evil spirits, and magic^{14, 15}.

1.2.2. Definition of terms:

1.2.2.1. Human rights (HR): are the fundamental rights that humans have by the fact of being human, and that are neither created nor can be abrogated by any government¹⁶.

1.2.2.2. Disability: is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment: is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations (WHO definition)⁵.

1.2.2.3. Attitude: a predisposition, toward any person, ideas or objects, it contains cognitive, affective and behavioural components¹⁷.

1.2.2.4. Psychosocial and Mental disability (PMD): is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities, used to describe the experience of people with impairments and participation restrictions related to mental health conditions. These impairments can include a loss of ability to function, think clearly, experience full physical health, and manage the social and emotional aspects of their lives¹⁸.

1.2.2.5. Mental illnesses (MI): are health conditions involving changes in thinking, emotion or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities¹⁹.

1.2.2.6. Stigma: is a combination of stereotyped beliefs, prejudiced attitudes, and discriminatory behaviors toward out-groups—but transcending each component, given the global nature of the aspersions cast—resulting in reduced life opportunities for those who are devalued²⁰. Stereotype: is a cognitive “shorthand” to describe a given social group, which may contain a germ of truth but which is likely to lead to rigid characterizations of group members²⁰. Prejudice: literally “prejudgment,” this term refers to negatively tinged affective responses to members of out-groups²⁰. Discrimination: the limitations on the rights of out-groups or those who are socially castigated; the behavioral component of stigmatization, beyond cognitive stereotypes and affective prejudices²⁰.

1.2.3. Literature on attitude:

1.2.3.1. Attitude concept: Allport defined an attitude as a mental or neural state of readiness, organized through experience, exerting a directive or dynamic influence on the individual's response to all objects and situations to which it is related²¹. According to Schneider, 'Attitudes are evaluative reactions to persons, objects, and events. This includes your beliefs and positive and negative feelings about the attitude object²². He also added that attitude can guide our experiences and decide the effects of experience on our behaviours²². Thus, individual's disposition becomes an attitude if it contains in some parts, aspects of knowing and acting²². Moreover affective component of our attitude consists of a person's evaluation of liking or emotional response to some objects or person¹⁷. The cognitive component refers to the way the object or person is perceived. It is in fact the mental picture formed in the individual's brain. This includes the person's thoughts, beliefs and knowledge about the object¹⁷. The behaviour component involves the person's overt acts directed towards another person or group of persons or objects¹⁷. A similar definitions is adopted by (Eagly & Chaiken) 'Attitudes are evaluations of a particular person, behavior, belief, or concept. For example, you probably hold attitudes toward the U.S. president (a person), Abortion (a behavior), affirmative action (a belief), or architecture (a concept)²³.

A simpler definition of attitude is a mindset or a tendency to act in a particular way due to both an individual's experience and temperament²². Baron and Byrne also gave a similar definition of attitude which is, 'Attitudes can be defined as lasting, general evaluations of people (including oneself), objects, or issues²⁴. Attitude is lasting because it persists across time. A momentary feeling does not count as an attitude²⁴. This is similar to a statement made by Vaughan & Hogg, 'Attitudes are relatively permanent-persist across times and situations²⁵. A momentary feeling in one place is not an attitude.' Therefore, if you encountered a brief feeling about something, it does not count as an attitude. Moreover, Vaughan & Hogg defined attitude as, 'A relatively enduring organization of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols or a general feeling or evaluation (positive/ negative) about some person, object or issue'²⁵. In brief, it could be said that, attitude is a positive or negative evaluations or feelings that people have towards other people, objects, issues or events, i.e. Attitude is the general way people feel towards socially significant objects and most attitudes are lasting²⁵.

1.2.3.2. Components of Attitude:

Components of attitudes can be categorized according to the ABC model. In the ABC model of attitude, 'A' represents to the affective components of attitude, 'B' represents to the behavioural components and 'C' represents the cognitive component of attitude²⁵.

The affective component of the attitude refers to how we feel about certain attitude objects. In other words, it refers to our emotional reactions towards the attitude object^{24, 25}. It includes our positive and negative feelings towards the object. Therefore, the affective component of an attitude reflects how much we like or dislike an attitude object. Meanwhile the behavioural component refers to our behavioural intentions, or how we act according to the attitude that we have. This component includes our behavioural tendency towards an attitude object. Basically, it refers to how we are inclined to act towards an attitude object^{24, 25}. The behavioural component of the attitude will determine how we act towards an attitude object. On the other hand, the cognitive component refers to what our knowledge of the attitude object. In other words, the cognitive component refers to what we know about the attitude object and the process that goes onto forming and using an attitude²⁴. The cognitive component of an attitude includes our thoughts and ideas about the attitude object²⁵. For example, a person's negative attitude towards a person with psychosocial disability could be divided into the three following components. Firstly, the affective component could be the person's negative feelings or fear towards the person with psychosocial. Then, the behavioural component could be the person's tendency to move away from that person or be guarded suspicious when he or she is near such person. Finally, the cognitive component could be the person's knowledge that persons with psychosocial disabilities are dangers and they can endanger people's lives.

1.2.3.3. Attitude formation and attitude change:

An attitude is formed by the excitation of a need in the individual. This need may arise within the individual or be triggered by a relevant cue in the environment. To induce attitude change the expression of an old attitude or its anticipated expression must be seen to give satisfaction no longer²⁴.

One way of changing people is to change their attitudes and opinions. Attitudinal change or opinion change is a type of change in which the change agent exercises social influence²³. This process of changing attitudes is called persuasion, one of the central concepts in social psychology. The ease with which attitudes can be changed depends on a number of factors, including:

Message source: attitude communicator who is physically and socially attractive produce greater attitude change than those who are less attractive; characteristic of the message: for example, two sided messages (communication that presents two points of view and then presents arguments to counter the opposing view) also called two-sided appeal, are more persuasive than one sided messages and characteristic of the target: for example intelligent people and men are more resistant to persuasion²³. Types of attitudes toward persons with psychosocial disability result in stigmatization of these people. Stigma has numerous negative effects on persons with psychosocial disability such as difficulties obtaining housing, discrimination among employers 'hiring practices, loss of family and social support, and self-stigma²⁶. The amount of stigma experienced is so powerful that some consumers report it is more debilitating than the illness itself²⁷. Essentially, the way people perceive and treat mental health clients is worse than the psychiatric symptoms they experience³. We need to be aware about the elements of attitude change to change attitudes towards persons with psychosocial and mental disabilities. It's time to look at the facts and dispel some of the myths surrounding mental illness.

1.2.3.4. What can we do about stigma and discrimination?

It is first important to have ongoing education regarding mental illness so people can understand what mental illness is and how it might impact those suffering to be ostracized and rejected. This education should be conducted by professional who are committed to the human rights, knowledgeable regarding mental illness and socially attractive and intelligent. We need to use central route processing rather than the peripheral route processing, to comprehend our messages regarding mental health issues because central route processing generally leads to stronger, more lasting attitude change²³. It is also important to offer support to those who might be trying to cope and deal with mental illness to let them know that it is not a weakness to admit to experiencing mental illness, rather strength to ask for help¹. This will also help those who are dealing with mental illness to come forward to receive the help they need.

1.2.4. Literature on human rights:

Human rights are almost a form of religion in today's world. They are the great ethical yardstick that is used to measure a government's treatment of its people. A broad consensus has emerged in the twentieth century on rhetoric

that frames judgment of nations against an international moral code prescribing certain benefits and treatment for all humans simply because they are human and within many nations political debates rage over the denial or abuse of human rights²⁸.

1.2.4.1. Theory of human rights:

(1) Human rights can be seen as primarily ethical demands. They are not principally “legal,” “proto-legal” or “ideal-legal” commands. Even though human rights can, and often do, inspire legislation, this is a further fact, rather than a constitutive characteristic of human rights²⁹.

(2) The importance of human rights relates to the significance of the freedoms that form the subject matter of these rights. Both the opportunity aspect and the process aspect of freedoms can figure in human rights. To qualify as the basis of human rights, the freedoms to be defended or advanced must satisfy some “threshold conditions” of (i) special importance and (ii) social influence-ability²⁸.

(3) Human rights generate reasons for action for agents who are in a position to help in the promoting or safeguarding of the underlying freedoms. The induced obligations primarily involve the duty to give reasonable consideration to the reasons for action and their practical implications, taking into account the relevant parameters of the individual case. The reasons for action can support both “perfect” obligations as well as “imperfect” ones, which are less precisely characterized. Even though they differ in content, imperfect obligations are correlative with human rights in much the same way as perfect obligations are. In particular, the acceptance of imperfect obligations goes beyond volunteered charity or elective virtues²⁸.

(4) The implementation of human rights can go well beyond legislation, and a theory of human rights cannot be sensibly confined within the juridical model in which it is frequently incarcerated. For example, public recognition and agitation (including the monitoring of violations) can be part of the obligations—often imperfect—generated by the acknowledgment of human rights. Also, some recognized human rights are not ideally legislated, but are better promoted through other means, including public discussion, appraisal and advocacy (a basic point that would have come as no surprise to Mary Wollstonecraft, whose *A Vindication of the Rights of Woman: with Strictures on Political and Moral Subjects* was published in 1792)²⁸.

(5) Human rights can include significant and influenceable economic and social freedoms. If they cannot be realized because of inadequate institutionalization, then, to work for institutional expansion or reform can

be a part of the obligations generated by the recognition of these rights. The current unrealizability of any accepted human right, which can be promoted through institutional or political change, does not, by itself, convert that claim into a non-right²⁹.

(6) The universality of human rights relates to the idea of survivability in unobstructed discussion—open to participation by persons across national boundaries. Partisanship is avoided not so much by taking either a conjunction, or an intersection, of the views respectively held by dominant voices in different societies across the world (including very repressive ones), but through an interactive process, in particular by examining what would survive in public discussion, given a reasonably free flow of information and uncurbed opportunity to discuss differing points of view. Adam Smith’s insistence that ethical scrutiny requires examining moral beliefs from, *inter alia*, “a certain distance” has a direct bearing on the connection of human rights to global public reasoning²⁹.

1.2.4.2. The Historical Origins of Human Rights:

In 539 B.C., the armies of Cyrus the Great, the first king of ancient Persia, conquered the city of Babylon. But it was his next actions that marked a major advance for Man. He freed the slaves, declared that all people had the right to choose their own religion, and established racial equality. These and other decrees were recorded on a baked-clay cylinder in the Akkadian language with cuneiform script³⁰.

Known today as the Cyrus Cylinder, this ancient record has now been recognized as the world’s first charter of human rights. It is translated into all six official languages of the United Nations and its provisions parallel the first four Articles of the Universal Declaration of Human Rights³⁰.

1.2.4.3. The Spread of Human Rights:

From Babylon, the idea of human rights spread quickly to India, Greece and eventually Rome. There the concept of “natural law” arose, in observation of the fact that people tended to follow certain unwritten laws in the course of life, and Roman law was based on rational ideas derived from the nature of things³¹.

Documents asserting individual rights, such as the Magna Carta (1215), the Petition of Right (1628), the US Constitution (1787), the French Declaration of the Rights of Man and of the Citizen (1789), and the US Bill of Rights (1791) are the written precursors to many of today’s human rights documents³¹.

The Magna Carta, or “Great Charter,” was arguably the most significant early influence on the extensive historical process that led to the rule of constitutional law today in the English-speaking world³¹.

By 1948, the United Nations’ new Human Rights Commission had captured the attention of the world. Under the dynamic chairmanship of Eleanor Roosevelt, the Commission set out to draft the document that became the Universal Declaration of Human Rights. Roosevelt, credited with its inspiration, referred to the Declaration as the “international Magna Carta for all mankind.” It was adopted by the United Nations on December 10, 1948³⁰. In its preamble and in Article 1, the Declaration unequivocally proclaims the inherent rights of all human beings. Article 1 “All human beings are born free and equal in dignity and rights³². They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”³² Human rights advocates agree that, sixty years after its issue, the Universal Declaration of Human Rights is still more a dream than reality. Violations exist in every part of the world. For example, Amnesty International and other sources show that individuals are:

Tortured or abused in at least 81 countries

Face unfair trials in at least 54 countries

Restricted in their freedom of expression in at least 77 countries

Not only that, but vulnerable groups such as women, children, ethnic minorities and persons with disabilities in particular are marginalized in numerous ways, the press is not free in many countries, and dissenters are silenced, too often permanently. While some gains have been made over the course of the last six decades, human rights violations still plague the world today³¹.

1.2.5. Human rights of persons with psychosocial and mental disabilities

1.2.5.1. Introduction:

People with mental illness have long been subjected to cruelty, neglect, ridicule, discrimination, marginalization, and stigma. The stigma associated with these conditions means that people experienced exclusion and rejection by the society³³. Stigma has been found to be a primary deterrent for individuals who need mental health services as well as impacting those already receiving services²⁰. World health organization (WHO) stated that: (All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination³. About 15% of the world's population lives with some form

of disability, of whom 2-4% experience significant difficulties in functioning³⁴.

Although in the last two decades, the world has witnessed a significant change in the quality of life and social participation of persons with psychosocial and mental disabilities, based on the issues of human rights, still there is a huge violation of the rights of this vulnerable group, in low and middle-income countries³⁵. Sudan is one of the low income group countries³⁶.

In Sudan, no national human rights review body exists. Review/inspection of human rights protection of patients in mental hospitals is sporadic and inconsistent. None of the mental health staff working in mental hospitals received any formal training on human rights¹².

The entry into force of the UN Convention on the Rights of Persons with Disabilities (CRPD) in May 2008 marked the beginning of a new era in the efforts “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity”⁴. Moreover CRPD adopted the social model of disability, in which the disability is recognized as the consequence of the interaction of the individual with an environment. Also psychiatric disabilities are included among other disabilities for the first time⁴.

1.2.5.2. Convention on the Rights of Persons with Disabilities (CRPD)

What is (CRPD)?

The Convention on the Rights of Persons with Disabilities is an international human rights treaty of the United Nations intended to protect the rights and dignity of persons with disabilities. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law. The Convention has served as the major catalyst in the global movement from viewing persons with disabilities as objects of charity, medical treatment and social protection towards viewing them as full and equal members of society, with human rights⁴.

The Convention adopts a social model of disability, and defines disability as including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. The text was adopted by the United Nations General Assembly on 13 December 2006, and opened for signature on 30 March 2007. Following ratification by

the 20th party, it came into force on 3 May 2008¹². Currently, Sudan is a party country to both the convention and the optional protocol³⁷. The Convention follows the civil law tradition, with a preamble, in which the principle that "all human rights are universal, indivisible, interdependent and interrelated" of Vienna Declaration and programme of Action is cited, followed by 50 articles. Unlike many UN covenants and conventions, it is not formally divided into parts⁴.

Summary of the convention:

Article 1 defines the purpose of the Convention: to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity

Articles 2 and 3 provide definitions and general principles including communication, reasonable accommodation and universal design.

Articles 4–32 define the rights of persons with disabilities and the obligations of states parties towards them. Many of these mirror rights affirmed in other UN conventions such as the International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights or the Convention Against Torture, but with specific obligations ensuring that they can be fully realized by persons with disabilities.

Rights specific to this convention include the rights to accessibility including the information technology, the rights to live independently and be included in the community (Article 19), to personal mobility (article 20), habilitation and rehabilitation (Article 26), and to participation in political and public life, and cultural life, recreation and sport (Articles 29 and 30).

In addition, parties to the Convention must raise awareness of the human rights of persons with disabilities (Article 8), and ensure access to roads, buildings, and information (Article 9).

Articles 33–39 govern reporting and monitoring of the convention by national human rights institutions (Article 33) and Committee on the Rights of Persons with Disabilities (Article 34).

Articles 40–50 govern ratification, entry into force, and amendment of the Convention. Article 49 also requires that the Convention be available in accessible formats.

Guiding principles of the Convention:

There are eight guiding principles that underlie the Convention:

Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons

Non-discrimination

Full and effective participation and inclusion in society

Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity

Equality of opportunity

Accessibility

Equality between men and women

Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

1.2.6. People with Mental Health Conditions as a Vulnerable Group:

1.2.6.1. Importance of mental health:

Positive mental health is linked to a range of development outcomes, including better health status, higher educational achievement, enhanced productivity and earnings, improved interpersonal relationships, better parenting, closer social connections and improved quality of life. Positive mental health is also fundamental to coping with adversity. On the other hand, poor mental health impedes an individual's capacity to realize their potential, work productively, and make a contribution to their community. The social and economic impact of mental and psychosocial disabilities is diverse and far-reaching, leading to homelessness, poor educational and health outcomes and high unemployment rates culminating in high rates of poverty. All these issues are directly linked to the Millennium Development Goals (MDGs)³⁸.

1.2.6.2. Impact of mental health problems:

Hundreds of millions of people worldwide have mental and psychosocial disabilities, including depression, schizophrenia, alcohol use disorders, epilepsy, and Alzheimer and other dementias. 80% of persons with mental health conditions live in low and middle income countries. Almost one million people die due to suicide every year, and it is the third leading cause of death among young people. Unipolar depressive disorders, schizophrenia, bipolar disorder and alcohol use disorders are placed among the top ten causes of disability due to health-related conditions in all countries, as well as in low and middle income countries, where they represent a total of 19.1 % of all disability related to health conditions³⁸.

1.2.6.3. Persons with mental and psychosocial disabilities comprise a vulnerable group for the following reasons:

They are subjected to high levels of stigma and discrimination, due to widely held misconceptions about the causes and nature of mental health conditions³⁸.

This group also experiences high levels of physical and sexual abuse. This can occur in a range of settings, including prisons and hospitals.

They often encounter restrictions in the exercise of their political and civil rights, largely due to the incorrect assumption that people with mental health conditions are not able to carry their responsibilities, manage their own affairs and make decisions about their lives³³.

In the majority of countries, people with mental and psychosocial disabilities are not able to participate fully in their societies by taking part in public affairs, such as policy decision-making processes. The majority of people with mental health conditions in low and middle income countries are not able to access essential health and social care. People with severe mental and psychosocial disabilities are also much less likely to receive treatment for physical illnesses^{2, 38}.

Emergency relief services also remain inaccessible for this group, in spite of the fact that their situations might worsen during the stress of emergencies. Emergency relief services often are inadequate to address the specific needs of people with mental and psychosocial disabilities. They also face significant barriers in attending school and finding employment. The exclusion of children with mental and psychosocial disabilities from education leads to further marginalization of this already vulnerable group. Poor educational outcomes also lead to poor employment opportunities. People with these disabilities experience the highest rates of unemployment of people with disabilities³.

Due to these factors, people with mental and psychosocial disabilities are much more likely to experience disability and die prematurely, compared with the general population.

Other vulnerable groups are also at risk of poor mental health, for example, marginalization and deprivation can result in poor self-esteem, low self-confidence, reduced motivation, feelings of hopelessness and isolation. Addressing mental health problems in vulnerable groups can facilitate development outcomes, including improved participation in economic, social, and civic activities.

People with mental health conditions have been largely ignored as a target of development efforts. This is despite the high prevalence of mental health conditions, their economic impact on individuals affected, their families and communities, and the associated stigmatization, discrimination and exclusion³⁸.

1.2.6.4. What still needs to be done?

The response requires a broad integrated strategy to improve mental health in low and middle income countries as recommended in WHO's Mental Health and Development report:

- a. Provide integrated mental and physical treatment and care through primary care. As treatment is affordable and cost effective, all health services should include a mental health component.
- b. Integrate mental health issues into broader health policies, programmes, and partnerships to avoid vertical systems of mental health services and marginalization of financing and human resources for mental health.
- c. Integrate mental health into services during and after emergencies for people with pre-existing mental and psychosocial disabilities, as well as those who develop chronic mental health problems as a result of the emergency, with a medium and long term focus on developing community based services.
- d. Include mental health issues within social services development and establish strong linkages between social services such as housing, health and mental health services.
- e. Mainstream mental health issues into education.
- f. Ensure that educational opportunities are both available and accessible, and that social barriers that might prevent children with mental and psychosocial disabilities from attending school are removed.
- g. Include people with mental health conditions in income-generating programmes.
- h. Employment programmes and other poverty alleviation initiatives such as small business grants and social security must reach out to people with mental health conditions.
- i. Strengthen human rights protections. Using the UN Convention on the Rights of Persons with Disabilities, highlights the need to develop and implement policies and laws that promote the rights of persons with mental and psychosocial disabilities, including the rights to autonomy, liberty, to exercise legal capacity and to live independently and be included in the community.
- j. Build the capacity to participate in public affairs. Promote and support the development of civil society groups for people with mental and psychosocial disabilities and facilitate their participation in decision-making processes including policy, planning, legislation and service development.

2. Part two

2.1. CHAPTER ONE - GROUNDS, OBJECTIVES AND HYPOTHESIS

Chapter I - GROUNDS, OBJECTIVES AND HYPOTHESIS

2.1.1. Grounds

2.1.1.1. Introduction:

Mental health in Sudan as in others African countries was exclusively monopolized by faith healers, Zar conductors, exorcists, and sheer quacks until the mid-twentieth century¹⁴. Neither the Kitchener army invading Sudan in 1898³⁹, nor the subsequent colonial administration, contemplated introducing any mental health component in their Military Medical Corps or in their later Sudan Medical Service⁴⁰. Neither had the established 1924 Kitchener School of Medicine (KSM) include any didactic or clinical instruction in mental health¹⁴. No wonder that none of the first generation of Sudanese graduates from KSM expressed any interest in dealing with patients with mental health problems¹⁴. The singular exception was a 1935 graduate who stunned his relatives and colleagues by his crazy decision (at that time) to choose mental health as a career. History of psychiatry in Sudan is closely related to Professor Tigani El-Mahi (1911-70) who was the first Sudanese and native African psychiatrist. He introduced the first psychiatric facility in Sudan. He later became the first Mental Health Advisor in the East Mediterranean Regional Office of the World Health Organization. He was the first professor of psychiatry in Sudan. His disciple, Taha Baasher (1922-2008), shared and carried forward El-Mahi's visions and plans. Their joint contributions constituted the tenets of what has become known as the El-Mahi-Baasher heritage^{14, 41}. Whenever the history of Psychiatry in the Sudan is discussed, it would be appropriate to mention El-Mahi and Baasher heritage.

El-Mahi founded the first Psychiatry clinic in Al Amlak district in Bahri city and in 1950 he co-founded Kober Mental Asylum⁴¹. Baasher founded many mental health institutes including Bahri psychiatry clinic in 1959, Khartoum Psychiatry clinic in 1962 and Tigani El-Mahi Teaching Hospital in 1971⁴¹. He is rightfully the genuine father of the so called "open-door psychiatry treatment policy", as he adopted accepting patients and their families for inpatients treatment, and rented houses near the clinic for that purpose⁴¹. Baasher also founded psychiatric units in all provinces of the Sudan. He and his colleagues started from the very beginning to bridge the gap between traditional healing and psychiatry^{14, 41}.

Tenets of El-Mahi-Baasher heritage as stated by Professor Sheikh Idris^{14, 41}:

- a. Develop mental health services starting from the base of the pyramid of the community, through outpatient facilities, to general hospital

- wards, to small-size short-stay psychiatric hospitals, to larger size longer-stay therapeutic rehabilitation hospitals.
- b. Recruit, train, and coordinate multi-disciplinary mental health teams
 - c. Involve, psycho-educate, and support the family as an essential partner in the prevention, treatment, and rehabilitation.
 - d. Incorporate mental health services in the general health program starting from the primary health care center.
 - e. Collaborate with respectable traditional healers, especially in reputable and time-honored faith-therapeutic villages.
 - f. Encourage scientific research with emphasis on epidemiology, psychopathology, therapeutics, socio-cultural and multidisciplinary studies.
 - g. Train and qualify future generations of mental health professionals in undergraduate, post-graduate, and continuous professional development.
 - h. Create and maintain active participation in local, regional and global professional organizations and activities.

2.1.1.2. Statement of the problem

Despite the advanced view of the pioneers in psychiatry at a very early time, unfortunately many obstacles prevented the achievement of what they wanted for mental health in Sudan. There were a substantial number of barriers to implement these principles in order to develop a good mental health system in the country. These barriers include stigma, human rights violations, lack of political will, professional barrier, lack of awareness, lack of trained mental health care provider, brain drainage, poverty and many other health problems that were considered as priorities by the stakeholders¹².

In Sudan, mental health system has three types of mental health facilities; classical psychiatric hospitals, psychiatric units in general hospitals and asylums. The vast majority of the tiny financial resources and a substantial part of human resources that are available are directed towards these facilities¹². Psychiatric hospitals and psychiatric units are run by the ministry of health. Asylums contain most of the chronic patients, homeless patients and patients with criminal responsibilities, are run by police and look like prisons. However most of these facilities need to be strengthened

and developed further in terms of staff, treatment facilities and living facilities¹². None of these facilities provide active follow-up care in the community and almost no professional community mental health service. Primary health care staff training on mental health issues is weak, as is interaction between the primary health and mental health system. There is an imbalance in favor of mental hospital inpatient care. Few facilities are devoted to children and adolescents¹².

Up to the moment of conducting this study, the asylums were the main facilities all over the country except Khartoum -the capital- for persons with psychosocial and mental disabilities who were kept in very narrow cells in an inhumane manner, wearing dirty clothes or no clothing at all. Very few medications were available as were trained staff members and if a patient becomes excited, then unmodified electroconvulsive therapy (ECT) is the only option!.

Since the attitude can predict behavior⁴², the researcher hypothesized that the staff and consumers attitudes toward human rights of persons with psychosocial and mental disabilities affect the extent to which the inclusion philosophy becomes reality.

The issues of human rights of people with psychosocial and mental disabilities worldwide are lagging behind. There is no national mental health legislation in 25% of countries with nearly 31% of the world's population. In the Eastern Mediterranean Region only 57% have such legislation³. Sudan's mental health policy was reformulated in 2006-2008. The last version of mental health legislation dates back to 1998 and requires updating¹² and the current mental health act draft which is under approval contains articles with major human rights violations. Up to the researcher knowledge until now there is no study addressing the attitude toward human rights of persons with psychosocial disabilities in Sudan. There are many studies of attitude toward persons with mental disorders were done in Sudan by many colleagues in the field of mental health, for instance Anas, 2011 and Khalid, 2015 among medical students and primary health care providers respectively. They revealed negative attitudes toward persons with psychosocial disabilities. But no one address the attitudes of mental health

care providers toward their patients or the attitudes of the consumers toward themselves or mental illness.

2.1.1.3. Significance of the study:

This study explored some of the major barriers that are preventing persons with psychosocial disabilities to experience their human rights (especially full inclusion and participation in the community), by examining the staff members' and consumers' attitudes toward this population's human rights. The results of this study will inform training to staff and consumers on human rights issues.

2.1.2. Objectives:

2.1.2.1. General Objective:

This study was designed to describe the attitudes of staff and consumers toward human rights of persons with psychosocial and mental disabilities and their integration in to the community, within Khartoum the capital city of Sudan.

2.1.2.2. Specific Objectives:

2.1.2.2.1. To bring to attention the issues of human rights of persons with psychosocial disabilities by examining staff's and consumers' attitudes toward these rights.

2.1.2.2.2. To provide information on the general attitudes of staff's and consumers' toward human rights.

2.1.2.2.3. To describe types of attitudes of staff and consumers toward human rights of persons with psychosocial and mental disability and their integration in to the community.

2.1.2.2.4. To explore the possible predictors of attitudes of staff and consumers toward human rights of persons with psychosocial and mental disability and their integration into the community.

2.1.2.2.5. To see the difference between staff's and consumers' attitudes toward human rights of persons with mental and psychosocial disability.

2.1.2.3. Subsidiary objective:

2.1.2.3.1. A step in the construction and the standardization of Human Rights of persons with psychosocial and mental disability attitude questionnaire (HRQ_6).

2.1.3. Study hypotheses:

2.1.3.1. Staff and consumers have negative attitudes toward the human rights of persons with psychosocial and mental disabilities which will affect the process of integration into the community.

Null hypothesis: Staff and consumers have neutral attitudes toward human rights of persons with psychosocial and mental disabilities

2.1.3.2. Staff member background variables including age, gender ,academic discipline, seniority, marital status, history of mental disorder, contact with psychiatric services as a user and the role, may have an effect on his/her attitudes toward human rights of persons with psychosocial and mental disabilities.

Null hypothesis: staff member background variables have no effect on his/her attitudes toward human rights of persons with psychosocial and mental disabilities.

2.1.3.3. Consumer background variables including age, gender, marital status, numbers of years using the service, diagnosis, level of education and self-esteem may have an effect on his/her attitudes toward human rights of persons with psychosocial and mental disabilities.

Null hypothesis: consumer background variables have no effect on his/her attitudes toward human rights of persons with psychosocial and mental disabilities.

2.1.3.4. Consumers' attitudes toward human rights of persons with psychosocial and mental disabilities will be more positive than the staff attitudes.

Null hypothesis: There will be no difference between the consumers' attitudes and the staff attitudes toward human rights of persons with psychosocial and mental disabilities.

2.2. CHAPTER TWO: METHODOLOGY

CHAPTER 2: METHODOLOGY

This chapter will describe the procedure upon which the research is based. A survey is devised and conducted in order to assess the attitudes of staff and consumers toward human rights of persons with psychosocial and mental disabilities and their integration in to the community .The main objective behind this survey was to guide and inform the training and raising the awareness that would be carried out amongst staff and consumers in Sudan, to better identify, accept and deal with patients of mental illness.

2.2.1. Study design:

This study was a non-experimental, cross-sectional descriptive, hospital based study.

2.2.2. Study population:

The participants for this study was consist of staff professionals (social workers, nurses, psychologist and doctors) and their patients.

The sample Number = 204, was consist of 100 consumers and 104 staff members. Participants were selected through convenience sampling.

Informed consent was obtained from all the participants. To ensure confidentiality, participant names were not taken and the samples were identified only by a number code. All others involved in the project were told that no information would be released about individual participants.

2.2.2.1. Criteria for participation in this study were including:

1. Professional staff member or consumer in one of the main three psychiatric hospitals in Khartoum.
2. Working at least for three months in mental health field (staff).
3. Accepting to participate in the study.

2.2.2.2Exclusion criteria were including:

1. Staff members who spent less than three months in mental health field.
2. Refusal to continue in the study at any time during the data collection.

2.2.3. Study area:

The study was carried out between May 2016 and February 2017 in Khartoum city, the capital of Sudan. It is a city of 8 million population^{6, 7} and three main psychiatric hospitals with around 400 beds and very busy outpatients (OPD) and emergency(ER) clinics with around 200 consumers

per day. The three main psychiatric hospitals in Khartoum, Sudan, where this study was conducted are:

(1) Tigani El-Mahi Teaching Hospital for Mental Health (EETHMH): this is the largest civil mental health in Sudan, was built in 1971 and named after Professor El-Mahi (Father of African Psychiatry) , founded in Omdurman (Khartoum west), and contains 100 beds¹⁵.

(2) Baasher hospital Psychiatric Hospital: is an extension of the first psychiatry facility in Sudan which founded by El-Mahi in 1950 and renewal by Baasher in 1959, in Bahri (Khartoum north), and contains 50 beds¹⁵.

(3) Elidrissi Psychiatric Hospital (EPH): is the state hospital for treating patients with mental illness and criminal responsibilities and patients who are dangerous to themselves or others, founded in Bahri (Khartoum north), and contains 250 beds¹⁵.

These hospitals are the major public psychiatric hospitals in Sudan, receive patients from all over the country and from different social classes .They act as the main tertiary hospitals for mental health in the country, although they can receive patients directly through OPD or ER, also they are the main hospitals for mental health training in Sudan.

The average of admission per day varies from three patients in Baasher hospital to ten patients in Tigani El-Mahi and Elidrissi¹⁵.

2.2.4. Sampling and recruitment:

Sampling was convenient sampling. After we have received permission, the questionnaire was distributed to the staff and the consumers who were satisfy the criteria, between May 2016 and February 2017. Every participant was met personally and given his/her questionnaire to ensure that he/she is responded to it. Participant was given Arabic language version of a questionnaire that took approximately 25 minutes to complete. The questionnaire included the Community Living Attitudes Scale Mental Retardation - Short Form (CLAS). The respondents were asked to indicate the extent to which they agreed or disagreed with the statements in the Community Living Attitudes Scale Mental Retardation - Short Form (CLAS), 17 items and Human Rights of persons with psychosocial and mental disabilities attitude questionnaire which is developed by the researcher based on CRPD (included some questions not found in the

CLAS). Each statement was scored by the respondent using a 6-point Likert-like scale.

2.2.5. Variables:

Two sets of data were collected:

2.2.5.1. a. Dependent variables:

Community Living Attitudes Scale (MR)-Short Form (CLAS), 17 items (Henry et al., 1996), Human Rights of persons with psychosocial and mental disabilities attitude questionnaire developed by the researcher based on CRPD, 25 items and one question regarding recovery (attainable or not).

2.2.5.2. b. Independent variables:

Gender

Age

Marital status

Children (consumers)

The responsibility towards self (consumers)

The responsibility towards others (consumers)

Academic discipline or level of education

Role or job

Number of years (working in or using the service)

History of mental illness (staff only) (HMI)

Close person history of mental illness (CPHMI)

Previous contact with mental health services as a user (staff only)

Training on human rights

2.2.6. Selection of instruments:

Three sets of instruments were developed:

2.2.6.1. a. Socio-demographic and other independent variable questionnaire was developed by the researcher with reference to exiting literature.

2.2.6.2. b. The Community Living Attitudes Scale Mental Retardation - Short Form (CLAS). The CLAS consists of 17 statements that comprise 4 discrete subscales. Each statement was scored by the respondent using a 6-point Likert-like scale. Subscale scores each indicate the respondent's views on items representative of the community inclusion philosophic paradigm. The subscales measure Empowerment (attitudes toward self-advocacy and empowerment), Exclusion (the desire of the respondent to exclude persons with psychosocial or mental disabilities from community life), Sheltering (the extent to which the respondent believes that persons with psychosocial or mental disabilities need to be sheltered or protected), and Similarity (the perceived similarity of persons with psychosocial or mental disabilities to oneself).

CLAS-MR — the Community Living Attitudes Scale, developed by Henry et. al., (Henry, Keys, Jopp, & Balcazar, 1996), based on the input of self-advocates. It focused on contemporary community-living philosophies. The original scale was developed for persons with psychiatric disabilities and dual diagnosis.

The scale was a 40-item measure consisting of four subscale measures: (a) Attitudes toward empowerment and self-advocacy (13 items); (b) The respondent's desire to exclude persons with mental retardation from community life (7 items); (c) The extent to which the respondent believes that persons with mental retardation need to be sheltered or protected (7 items); (d) The perceived similarity of persons with mental retardation to oneself (12 items). These subscales demonstrated acceptable internal consistency (.75-.86), and retest reliability (.70-.75) in one month. Evidence for construct validity was found to be in correlation with other attitude scales. Correlation with a measure of social desirability showed that the subscales were relatively free of social desirability bias (Henry et al., 1996).

The full form of the scale was used in Israeli by (Duvdevany, 2008) to examine Staff and Consumer Attitudes toward Integration of Persons with Psychiatric Disability into the Community. The 17-item CLAS-MR was developed by Henry, Keys, and Jopp (1999) by choosing four or five of the most representative items in each subscale of the full form of the scale. An Arabic translation of the short form of the CLAS-MR was used in the present study. A comparison of the two versions was then carried out.

The Cronbach's alphas of the subscales of the short form were as follows: Empowerment = .67, Exclusion = .85, Sheltering = .72, and Similarity = .79 (Henry et al., 1999). The short form was significantly and highly correlated with the full form, with correlation coefficients for the subscales ranging from .78 to .94 (Henry et al.). A more recent British study also found high correlations between the subscales of the long and short forms of the CLAS-MR (.82 to .91; Scior, Addai-Davis, Kenyon, & Sheridan, 2013). The short form of the CLAS-MR was used in order to reduce the response time and thus encourage participation. Many authors have used this short form, Hélène Ouellette-Kuntz et al., 2003, have used it in Canadian senior psychiatry residents. Their result indicated that the attitudes of senior psychiatry residents toward persons with intellectual disabilities are not entirely consistent with the community living philosophic paradigm. Also used by Hui Su et al., 2015 in China to examine the applicability of the short form of the CLAS-MR for use with mainland Chinese community members. They found that, the original four-factor structure of the short form of the CLAS-MR did not fit the Chinese sample adequately. The items of the original Empowerment and Sheltering subscales were removed in the modified CLAS-MR due to absence of sufficient correlations with other items, while most items of the Exclusion and Similarity subscales were retained on their original subscales.

2.2.6.3. c. Human Rights of persons with psychosocial disability attitude questionnaire (HRQ_6), developed by the researcher, based on CRPD (includes questions not found in the CLAS). It consists of 24 items. Each statement was scored by the respondent using a 6-point Likert-like scale.

2.2.7. Adaptation, translation, back-translation procedure:

Adaption process was carried out for Arabic version. Six experts of mental health professionals, 2 psychiatrists, 2 psychologists and 2 social workers, were consulted to adapt concepts to the cultural background in Sudan.

Translation to Arabic and back-translation procedures was carried out by two professional translators with assistance of mental health experts. Since all the participants were native Arabic speakers, every participant was asked to fill one Arabic copy of the questionnaire.

2.2.8. Statistical analysis:

After the data was collected, they were entered into SPSS 16.0 for Windows. Descriptive statistics was explored initially to observe the patterns in the data as well as to examine the normality of the dependent variables.

Multiple analyses was conducted to determine the relationships between the independent variables, demographics, and the CLAS scale and Bivariate analyses was performed to examine the predictive ability of each independent variable in relation to each of the dependent variables.

The t-test was utilized to determine whether significant differences existed between staff and consumers mean attitudes scores.

Multivariate analysis of variance (MANOVA) was used to determine if a difference exists between groups of the independent variables on a linear combination of the dependent variables.

2.2.9. Ethical considerations:

Permission was obtained from the General Director of Health Affairs in Khartoum. Every participant was introduced directly to the aims and procedures of the study to decide if s/he would like to participate. After that, the questionnaire was given to the participant and his/her response will be confidential. Participants were given freedom to withdraw from the study at any part of the procedure.

2.2.10. Reporting and Dissemination

The results of this study are submitted in Partial Fulfillment of the Requirements for the Degree Master of International Mental Health in the Medical School of New University of Lisbon, Portugal, in April 2017.

Also the results will be reported to the stakeholders of mental health in Sudan as well as the key persons in mental health field in the region and worldwide.

2.3. CHAPTER THREE: RESULTS

CHAPTER 3: RESULTS

2.3.1. Survey Respondents

One hundred (100) consumers (49%) and one hundred and four (104) staff members (51%) from the main three psychiatric hospitals in Sudan agreed to complete our survey and returned usable questionnaires. The respondents ranged in age from 17 to 70 years (mean 32.34 years, SD 10.31). Over one-half were women (52.5%). Just less than one-half were single (47.5%), divorced were (10.8%), (6.5%) were widowed and one third 33.8% were married. Of the consumers (42%) had children (mean 4.32 years, SD 2.14), but (20%) of them were not willing to report the number of their children. From the consumers (12%) at least had a university degree, the majority (68%) received only primary or secondary education and (18%) didn't receive any type of formal education. The respondents were distributed across the following three main psychiatric hospitals in Sudan in proportions approximately representative of the distribution of beds available across the hospitals: El-Mahi (32.8); Baasher (25%) and Elidrissi (42.2%). Half of the consumers (50%) indicated that they were unemployed (22%) or unskilled laborer (28%), only (10%) were officers, (13%) were students and 3% were technicians. The staff members were distributed across the following four jobs in proportions approximately representative of the distribution of the staff available across mental hospitals in Sudan during day time: psychologist 38.5%, doctors (27.9%), nurses (25%) and social workers (8.7%). Few people (17.3%) of staff members had post graduate studies in mental health field. Staff members who were working in mental health field for more than 10 years were (22.1%), and the majority (63.5%) was working for less than 5 years. From staff members (14.4%) reported that they had experienced psychosocial or mental health problems, (43.3%) had experienced mental health problems with their relatives or close friends and over one half of them (51.9%) had contacted mental health services as users. Only (15%) of the consumers and (27.9%) of the staff members reported that they had some training in human rights. Only one third of each group (consumers 35% & staff 34.6%) believe that recovery from mental illness is

attainable for everyone; while (11%) of the consumers believe that recovery is not attainable at all from mental illness, none of the staff members believes so; the majority of both groups (54% from the consumers and 63.5% of the staff members) believe that recovery is attainable only for some clients. Some consumers were spent more than ten years with mental illness (5%) and more than one half (53%) suffer from mental illness for less than five years. Twenty seven consumers (27%) indicated that they carried the full responsibility toward self and eighteen (18%) reported that the responsibility toward oneself was carried out fully by others. Forty five consumers Less than one-half (45%) reported that they were looking after other people such as children or parents.

Figure 1: Percentage of the respondents according to their age:

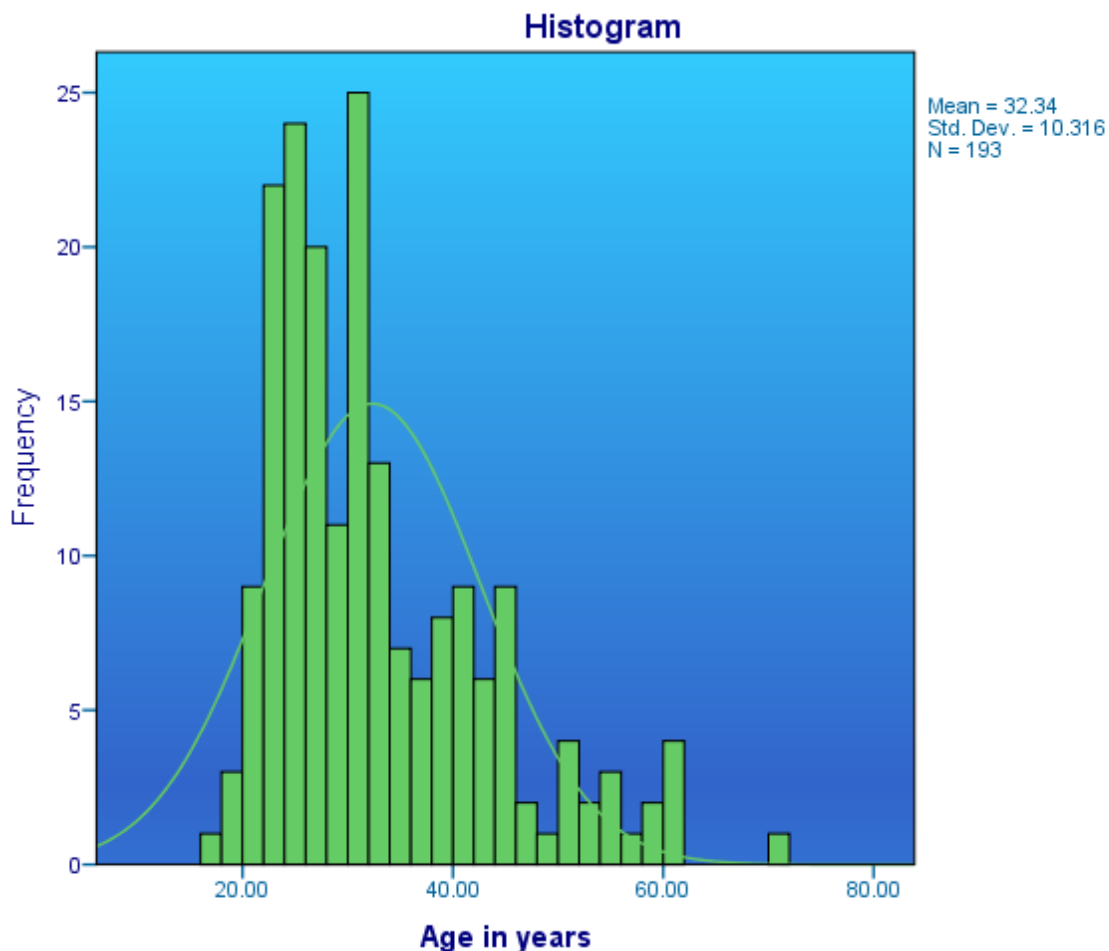
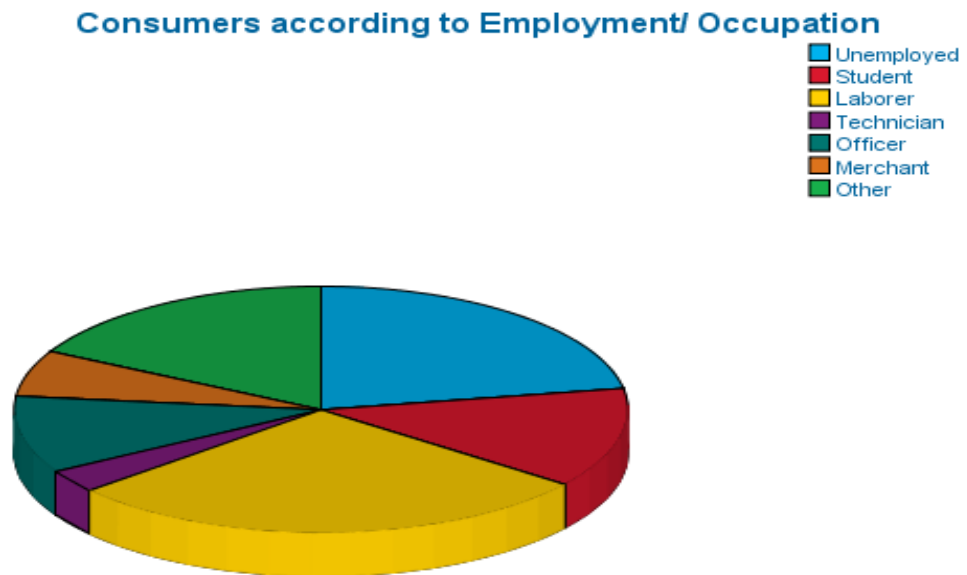


Table 1: Selected Demographics for the respondents:

Variable		Frequency	Percent
Hospital	El-Mahi	67	32.8
	Baasher	51	25.0
	El-Edrisi	86	42.2
	Total	204	100.0
Type	Consumer	100	49.0
	Staff	104	51.0
	Total	204	100.0
Gender	Male	96	47.1
	Female	106	52.0
	Total	202	99.0
Marital status	Married	69	33.8
	Single	97	47.5
	Widowed	13	6.4
	Divorce	22	10.8
	Total	201	98.5

Figure 2: Percentage of the consumers according to their occupation:



2.3.2. Participants' Attitudes:

As measured by the attitude toward Human Rights of persons with psychosocial and mental disabilities Questionnaire (HRQ_6) and the Community Living Attitude Scale-short form (CLAS), the respondents' views toward human rights of persons with psychosocial and mental disability can be characterized as negative attitude that was below or just at the minimal response that in favor of basic human rights of those people, which was (4.00 for HRQ_6, Empowerment and Similarity and 2:00 for Isolation and Sheltering). HRQ_6 mean was (3.76) and SD was (0.44), CLAS subscales empowerment (attitudes toward self-advocacy and empowerment) and similarity (the perceived similarity of persons with psychosocial and mental disabilities to oneself) were as follows: empowerment mean was (4.00) and SD was 0.78 and similarity mean was 4.36 and SD was 0.76. CLAS subscales exclusion (the desire of the respondent to exclude persons with psychosocial and mental disabilities from community life) and sheltering (the extent to which the respondent believes that persons with psychosocial and mental disabilities need to be sheltered or protected) were as follows: exclusion mean was (2.40) and SD was 1.00 and sheltering mean was (3.83) and SD was 0.83.

The respondents were favoring Empowerment and Similarity over Exclusion and Sheltering

Table (2) provides the mean for the HRQ_6 item scores:

The question	N	Min i	Max	Mean	SD
1. In Sudan no need for mental health legislation to protect the rights of persons with psychosocial and mental disabilities.	204	1.00	6.00	4.5098	1.47053
2. All nations should work toward liberty and justice for all including persons with psychosocial and mental disabilities	204	1.00	6.00	4.6029	1.27275
3. Persons with psychosocial and mental disabilities should be able to have a voice in how they deal with their own	204	1.00	6.00	4.5147	1.17644

physical well-being, with their health and with their illnesses					
4. Persons with psychosocial and mental disabilities should be able to lead, control, exercise choice over, and determine their own path of recovery	204	1.00	6.00	4.1324	1.16903
5. Occasionally it is reasonable to deny the right to vote to some groups of persons with psychosocial and mental disabilities; for instance to persons with sever types of schizophrenia	204	1.00	6.00	3.1814	1.29472
6. Teenagers with psychosocial and mental disability should be allowed to receive all types of medical and psychosocial treatments without parental consent	204	1.00	6.00	3.3088	1.54974
7. It is legitimate for authorities to curtail the activities of persons with psychosocial and mental disabilities which are socially unacceptable; for instance wandering along the street with dirty clothes	204	1.00	6.00	3.2402	1.51060
8. All citizens should be given full constitutional rights but citizens with psychosocial and mental disabilities should not expect to be given all those rights	204	1.00	6.00	3.6814	1.47606
9. Persons with psychosocial and mental disabilities should not have to worry about unwarranted intrusions by the government, family and friends into their private lives	204	1.00	6.00	3.2598	1.39533
10. Books should be banned if they are written by persons with psychosocial and mental disabilities who have been in acute psychotic state during the time of writing.	204	1.00	6.00	3.7451	1.42245
11. Police should not have to get search warrants when they are pursuing suspects with known severe mental illness.	204	1.00	6.00	3.4902	1.50366
12. Discrimination against because of psychosocial and mental disability is justifiable sometimes	204	1.00	6.00	3.2304	1.25194
13. We should not waste time to support persons with psychosocial or mental disabilities to take their decisions about self, when we are 100% sure they are not able to make decisions	204	1.00	6.00	3.5931	1.39180
14. Persons with psychosocial and mental disabilities should have the right to involve the traditional healers in their management plan	204	1.00	6.00	3.8725	1.26079
15. Persons with psychosocial and mental disabilities probably shouldn't be hired for jobs requiring considerable contact with the public since they could behave in a strange way	204	1.00	6.00	3.6765	1.43950
16. As soon as a person shows signs of mental disturbance, he should be hospitalized	204	1.00	6.00	2.6127	1.25240
17. Counselors should encourage persons with psychosocial and mental disabilities to consider training to become doctors, pilots, carpenters, military officers and other occupations that fit with their potentials regardless to their illness	204	1.00	6.00	3.7843	1.40462
18. For persons with psychosocial and mental disabilities is better to give welfare assistance rather than to encourage employment in order to protect them	204	1.00	6.00	3.4167	1.37103
19. Freedom of speech should be a basic human right except for persons with psychosocial and mental disabilities because they can embarrass their families and friends	204	1.00	6.00	3.8529	1.53384

20. The environment should be adapted to the needs of persons with psychosocial and mental disabilities even if doing so is expensive	204	1.00	6.00	4.2990	1.28032
21. The Convention on the Rights of Persons with Disabilities (CRPD) could disrupt society with its emphasis on treating persons with psychosocial and mental disabilities like others	204	1.00	6.00	3.7647	1.27249
22. Teachers with psychosocial and mental disabilities can be good role models for our children, just like anyone else.	204	1.00	6.00	4.0686	1.37364
23. Publishers, speakers, professionals and others since they are not intending stigma can use stigmatizing terms such as psychotic, schizophrenic and demented instead of usual terms such as persons with psychosis, with schizophrenia and with dementia.	204	1.00	6.00	3.7696	1.38281
24. Persons with psychosocial and mental disabilities should enjoy legal capacity on an equal basis with others in all aspects of life.	204	1.00	6.00	3.7941	1.31560
25. Persons with psychosocial and mental disabilities should not be deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.	204	1.00	6.00	4.2353	1.28789

	N	Mini	Max	Mean	SD
Human Rights of persons with psychosocial and mental disabilities attitude Questionnaire (HRQ_6)	204	2.46	5.28	3.7648	.43954

Figure (3) provides the HRQ_6 means distribution:

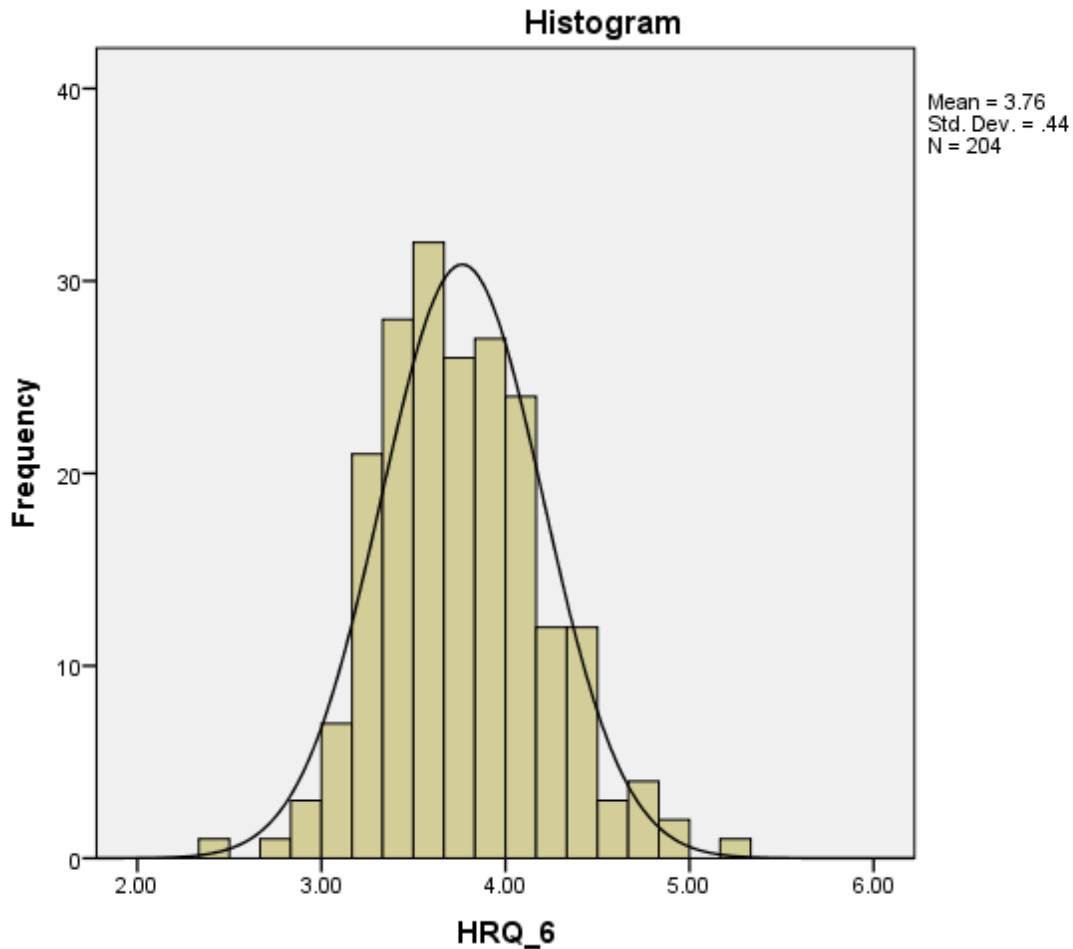


Table 3 provides the means and standard deviations for the CLAS items and subscales.

The questions	N	Mini	Max	Mean	SD
1. Persons with psychosocial and mental disabilities should not be allowed to marry and have children	203	1.00	6.00	4.487 7	1.3692 5
2. A person would be foolish to marry a person with psychosocial and mental Disability	204	1.00	6.00	4.465 7	1.3182 3
3. Persons with psychosocial and mental disabilities can plan meetings and conferences without assistance from others	201	1.00	6.00	4.487 7	1.2102 2
4. Persons with psychosocial and mental disabilities can be trusted to handle money responsibly	201	1.00	6.00	4.465 7	1.2496 6
5. The opinion of a person with psychosocial and mental disability should carry more weight than those of family members and professionals in decisions affecting that person	204	1.00	6.00	3.776 1	1.1490 8
6. Sheltered workshops for persons with psychosocial and mental disabilities are essential	204	1.00	6.00	3.671 6	1.2332 8

7. Increased spending on programs for persons with psychosocial and mental disabilities is a waste of tax dollars	203	1.00	6.00	3.568 6	1.2116 4
8. Homes and services for persons with psychosocial and mental disabilities downgrade the neighborhoods they are in	202	1.00	6.00	3.965 7	1.3229 1
9. Persons with psychosocial and mental disabilities are a burden to society	203	1.00	6.00	2.275 9	1.1539 1
10. Homes and services for persons with psychosocial and mental disabilities should be kept out of residential neighborhoods	203	1.00	6.00	2.707 9	1.3608 7
11. Persons with psychosocial and mental disabilities need someone to plan their activities for them	203	1.00	5.00	2.172 4	1.2113 2
12. Persons with psychosocial and mental disabilities do not need to make choices about the things they will do each day	203	1.00	6.00	2.443 3	1.2509 4
13. Persons with psychosocial and mental disabilities can be productive members of society	202	2.00	6.00	3.886 7	1.0660 7
14. Persons with psychosocial and mental disabilities have goals for their lives like other people	202	1.00	6.00	3.443 3	.97154
15. Persons with psychosocial and mental disabilities can have close personal relationships just like everyone else	203	1.00	6.00	4.673 3	1.0910 6
16. Persons with psychosocial and mental disabilities should live in sheltered facilities because of the danger of life in the community	203	1.00	6.00	4.683 2	1.2944 3
17. Persons with psychosocial and mental disabilities usually should be in group homes or other facilities where they can have the help and support of staff	203	1.00	6.00	4.645 3	1.2915 7

Subscale	N	Mini	Max	Mean	SD
Empowerment	197	2.20	5.80	4.0030	.78180
Exclusion	200	1.00	5.00	2.4050	1.00675
Sheltering	203	1.50	5.75	3.8313	.82776
Similarity	201	2.50	6.00	4.3570	.75730

The staffs' mean scores differed from those of the consumers (more positive) on the HRQ_6 and the CLAS subscales Empowerment, Exclusion, Sheltering and Similarity subscales.

Staff had more positive attitudes than the consumers in HRQ_6 (mean 3.92 vs 3.60, $t = 5.32$, $df = 202$, $P < 0.000$); and in the four CLAS factors, Empowerment (mean 4.15 vs 3.85, $t = 2.68$, $df = 195$, $P < 0.008$), Similarity (mean 4.65 vs 4.05, $t = 6.09$, $df = 199$, $P < 0.00$), Exclusion (mean 1.96 vs 2.87, $t = 7.22$, $df = 198$, $P < 0.000$) and Sheltering (mean 3.66 vs 4.01, $t = 3.14$, $df = 202$, $P < 0.002$).

Table 4 reports (HRQ_6) & CLAS subscale means for the comparison between staff and consumers.

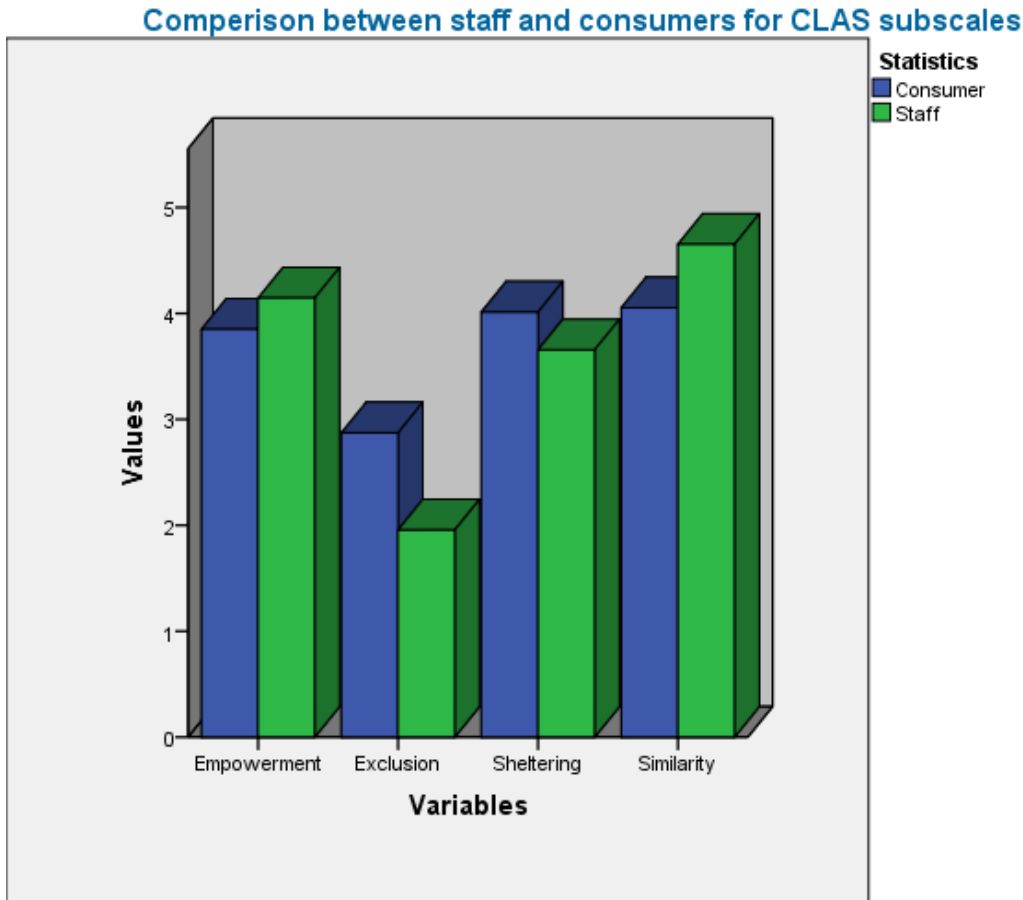
HRQ_6:

Consumer or Staff	Mean	N	Std.
Consumer	3.6079	100	.34177
Staff	3.9156	104	.47078
Total	3.7648	204	.43954

CLAS subscales:

Consumer or Staff		Empowerment	Exclusion	Sheltering	Similarity
Consumer	Mean	3.8505	2.8724	4.0125	4.0530
	N	95	98	100	99
	Std. Deviation	.87809	.94518	.62802	.71898
Staff	Mean	4.1451	1.9559	3.6553	4.6520
	N	102	102	103	102
	Std. Deviation	.65289	.85046	.95430	.67501
Total	Mean	4.0030	2.4050	3.8313	4.3570
	N	197	200	203	201
	Std. Deviation	.78180	1.00675	.82776	.75730

Figure (4) provides comparison between staff and consumers on CLAS subscale scores:



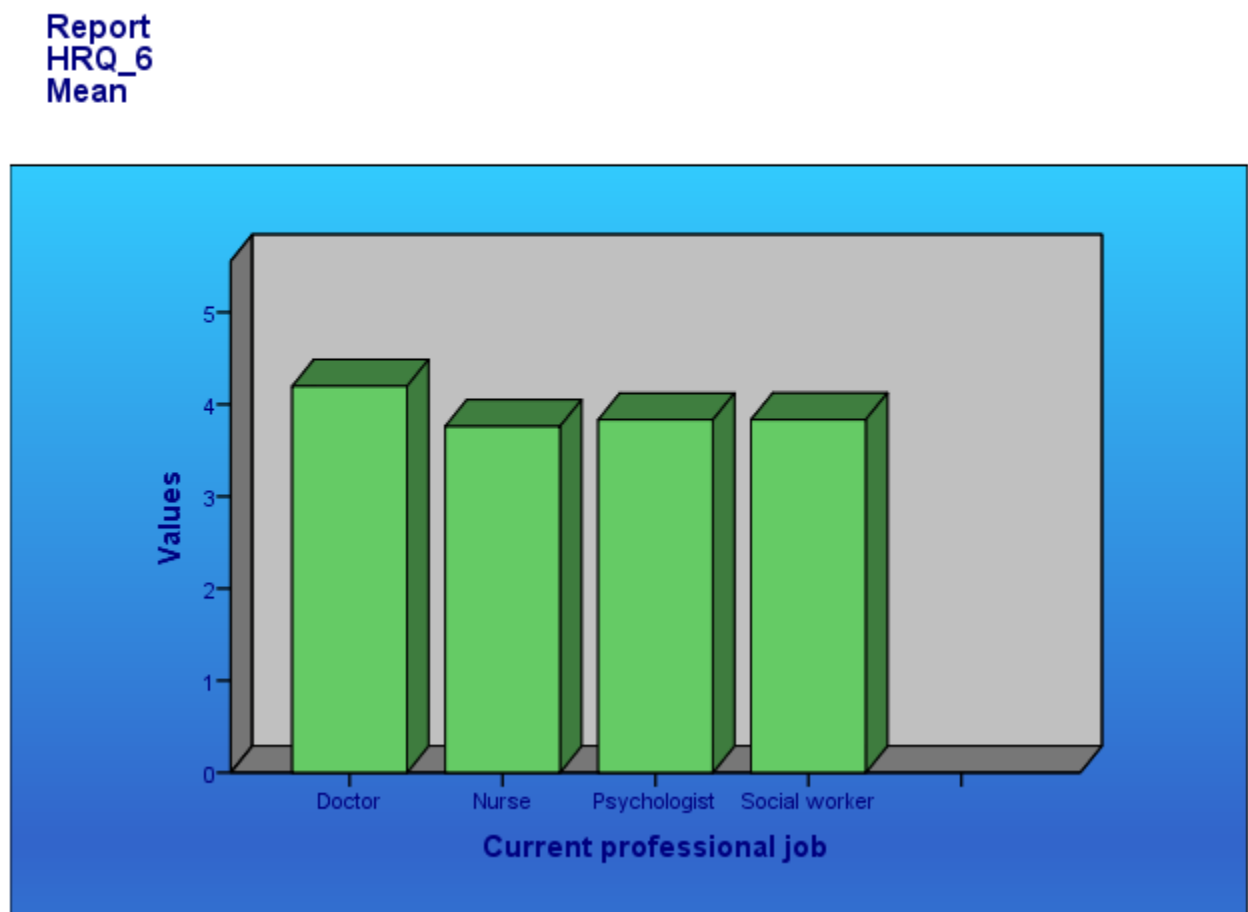
Female participants had more positive attitudes than male participants in three factors: exclusion, sheltering and similarity and P values were ($P < 0.015$, $P < 0.002$ & $P < 0.014$ respectively).

Participants from Eledrisi psychiatric hospital in comparison with the participants from the other two hospitals had more negative attitudes in HRQ_6 ($P < 0.006$).

While the consumers from Eledrisi psychiatric hospital had more positive attitudes in empowerment factor ($P < 0.002$), the consumers from El-Mahi psychiatric hospital had more negative attitudes in exclusion factor ($P < 0.000$).

Doctors had more positive attitudes than the other professional groups (psychologists, social workers and nurses) in HRQ_6 ($P < 0.001$) and three factors of CLAS which were Empowerment ($P < 0.043$), Similarity ($P < 0.004$), and Sheltering ($P < 0.000$).

Figure (5) provides the HRQ_6 means comparison between different staff professional groups:



Those from the staff members who had received lower educational level (Diploma), working more than 10 years in mental health field and nurses revealed more negative attitudes toward similarity factor than the corresponding groups from the staff members, P values were ($P < 0.004$, $P < 0.013$ & $P < 0.004$ respectively).

Those from the consumers who were divorce revealed more positive attitudes toward similarity factor than other groups ($P < 0.008$), while from the staff the single and widowed groups revealed more positive attitudes in empowerment and similarity, P values were ($P < 0.019$ & $P < 0.000$ respectively).

Those from the consumers who had other people under their direct responsibility revealed more positive attitudes toward empowerment and similarity factors than those hadn't; P values were ($P < 0.001$ & $P < 0.02$ respectively).

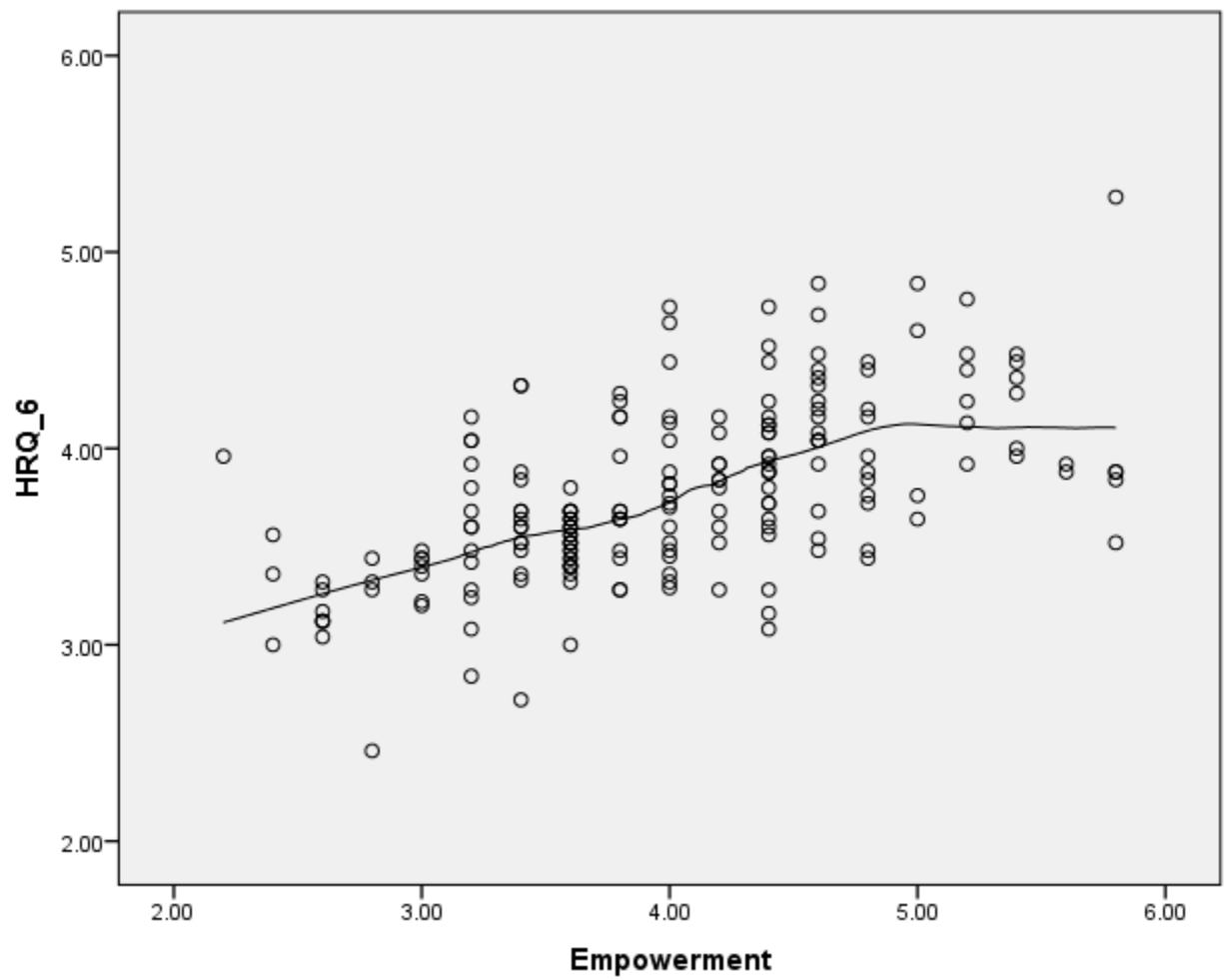
From the staff, those who had experienced direct psychosocial or mental health trouble with one of the close relatives or friends revealed significant positive attitudes in Exclusion factor ($P < 0.048$).

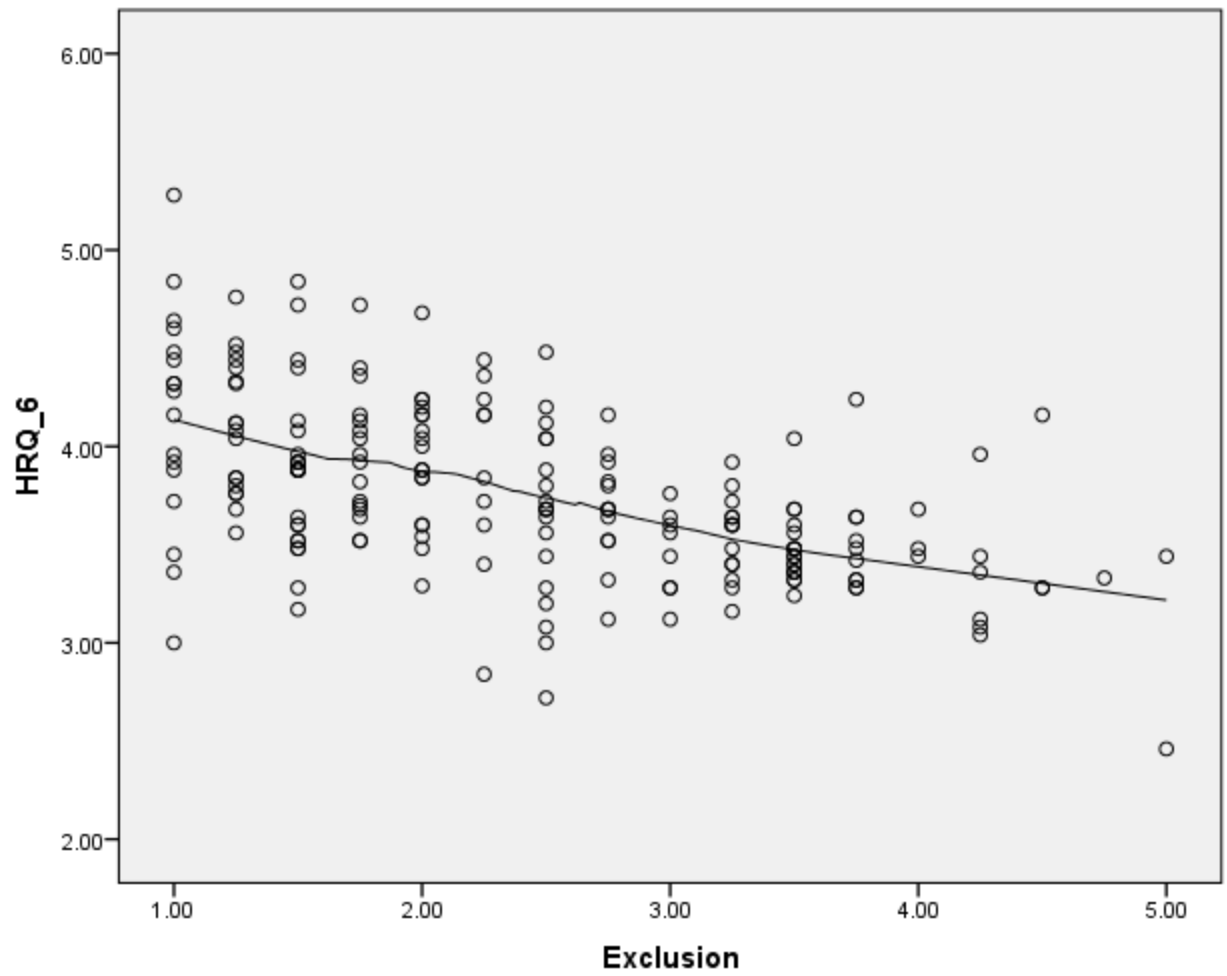
Staff training on human rights didn't reveal any more positive attitudes in HRQ_6 or CLAS four factors.

The relationship between independent variables and the question regarding recovery from mental illness was examined by Chi-Square test. Staff, participants from El-Mahi hospital, doctors, consumers who were fully responsible towards self and middle age groups (30 -50 years) revealed more positive attitude towards recovery from mental illness; P values were ($P < 0.002$, $P < 0.018$, $P < 0.002$, $P < 0.018$ & $P < 0.000$ respectively).

There was significant positive correlation between (HRQ_6) and CLAS subscales empowerment ($P < 0.000$) and similarity ($P < 0.000$), while there was significant negative correlation between (HRQ_6) and CLAS subscales exclusion ($P < 0.000$) and sheltering ($P < 0.000$).

Figure (6) reports the correlation between (HRQ_6) & CLAS subscales (empowerment & exclusion).





2.4. CHAPTER FOUR: DISCUSSION

CHAPTER 4: DISCUSSION

2.4.1. Discussion:

To our knowledge, this is the first investigation of attitudes toward human rights of persons with psychosocial and mental disabilities in Sudan and the region. In this study, we examined the attitudes of consumers and staff members concerning the human rights of persons with psychosocial and mental disability in Sudan. Protection of human rights of those people not only can make the inclusion philosophy reality but also can promote recovery oriented mental health practice^{1, 2}. The examination was conducted according to Gender, Age, Marital status, Having children or not (consumers), Responsibility towards self (consumers), Responsibility towards others (consumers), Academic discipline or level of education, Professional role or Occupation, Number of years (working in or Using the service), History of mental illness (staff), Close person history of mental illness, Previous contact to mental health services as a user (staff) and Training on human rights. The attitudes were measured according to HRQ_6 (the attitude toward Human Rights of persons with psychosocial and mental disability Questionnaire) and CLAS four factors: empowerment (attitudes toward self-advocacy and empowerment), sheltering (the need for sheltered settings), exclusion (the need to segregate them from the regular population) and similarity (to what extent they are different or similar to general population).

High scores on HRQ_6, empowerment and similarity and low scores on sheltering and exclusion, point to positive attitudes toward human rights of persons with psychosocial and mental disability.

This study found patterns of difference between staff and consumers, differences by profession and demographic differences in the HRQ_6, the 4 dimensions tapped by the CLAS and the recovery question. In this study also HRQ_6 found to be a reliable tool that can predict the score of CLAS subscales.

Comparisons of the staff (managers and professionals working in the mental health hospitals in Sudan) with consumers (the patients who receiving

mental health services in Sudan), samples showed that both groups had negative attitudes toward human rights of persons with psychosocial and mental disability. These negative attitudes are consistent with WHO report on mental health in Sudan which revealed that human right issues in Sudan are sporadic and inconsistent¹². This pattern of attitudes is parallel to the negative attitudes toward rights of persons with psychosocial and mental disability worldwide^{3, 34, 35 and 43}

The respondents generally were favoring Empowerment and Similarity over Exclusion and Sheltering. This relatively positive attitude may be explained in part by the innate desire for justice and equality⁴⁴ and the effect of different types of media after *Arab Spring*.

The staff sample had positive attitudes than the consumers sample on the HRQ_6 and all CALS four subscales and this confirm our hypothesis that staff will have more positive attitudes toward human rights of persons with mental health problems than the consumers. This result is in contrast with (Duvdevany) who found that the consumers' attitudes were more positive in relation to empowerment than those of their staff⁴⁵. But in the exclusion, similarity and sheltering factors, no differences were found between staff and consumers. This difference could be explained by the fact that consumers sample in Duvdevany study, were a community sample; more over the consumers awareness in Israel regarding their rights might be was much better than that in Sudan.

Sex differences in attitude were noted; female participants had more positive attitudes than male participants toward inclusion of persons with mental health problem in the community.

This pattern of findings may be consistent with a previous study by Cross SE & Madson L from USA that suggests women are more oriented toward relationships, interdependence, and empathy than are men⁴⁶.

The negative attitudes toward human rights of the participants from Eledrisi hospital on HRQ_6 may be explained by the fact that this hospital is run by police and includes patients with criminal cases.

In Sudan since the medical model of disability is predominated, doctors are the only directly involved staff who make decisions regarding assessment and management, other professionals in the team play minor roles and they are involved only when the doctor asks them to do some sort of intervention, e.g. doctors give order of oral medications in inpatient as well as in outpatient setting directly to the family members who nurse the patient throughout the illness and not to the nurse who is involved only in parenteral medications and electroconvulsive therapy (ECT)!. Our findings support the previous work of Alfred Ngirababyeyi from Rwanda (Ngirababyeyi, A, 2012) who revealed that, directly involved staff showed more positive attitudes toward inclusion of patients with mental disorder; doctors in our study had more positive attitudes than the other professional groups (psychologists, social workers and nurses).

The above result (doctors have more positive attitudes toward persons with psychosocial disability) coupled with our finding that, (those from the staff members who had received lower educational level (Diploma) had negative attitudes toward similarity factor than those who receive higher educational levels) could confirm previous studies from Israel (Duvdevany, 2000; Henry, Keyss, Balacazar, & Jopp, 1996). In these studies the higher the staff members' position, the more liberal and humanistic are their attitudes. They tend to be less authoritative, restrictive and less stigmatic toward persons with mental disability. In fact, in Sudan the mental health staff members who receive only diploma (most of them are nurses) rarely they expose to training or educational subject regarding mental health issues. Therefore these results could confirm a previous study from USA by Hunt Courtney Shelton & Hunt Brandon in 2004. In this study they found that the educational intervention had a significant impact on both participants' knowledge levels and their attitudes, even after controlling for gender and prior experience with people with disabilities

Those from the staff members who were working more than 10 years in mental health field had more negative attitude toward similarity factor, this result confirm previous studies from Israel such as (Duvdevany, 2008) which confirm the previous studies (Duvdevany, 2000; Henry et al., 1996b; McReynold, Ward, & Singer, 2002) and stated that young persons have

more positive attitudes than older people. They are more tolerant and liberal than older members of staff. As they acquire greater seniority in the field, they tend to keep more of a distance and view psychiatric disabilities more scientifically than humanistic ally.

Those from the consumers who had other people under their direct responsibility revealed more positive attitudes toward empowerment and similarity factors, this result can confirm a previous study from USA (Ryan D. Kmet, 2013) who revealed the positive effect of altruism on self-esteem and cognition.

From the staff, those who had experienced direct psychosocial or mental health trouble with one of the close relatives or friends revealed significant positive attitudes in Exclusion factor. This result may confirm the international studies which showed that contact with people with mental illness can result in positive attitudes toward those people, as well as increases the level of comfort in interacting with them (e.g., Gething & Wheeler, 1992; Arens, 1993; Beckwith & Mathews, 1994; Nikolaos Kazantzis , 2009).

In this study staff training on human rights didn't reveal any more positive attitudes; this may explained that the training didn't have the desired effect. It can be due to poorly designed programmes, an ineffective trainers or inadequate time for training.

Interesting enough we found that, doctors in this study had more positive attitudes toward recovery from mental illness than other professional groups. This result recalls optimism regarding the future of reform of mental health in Sudan, because most of the mental health programs are led by doctors.

The positive attitudes regarding recovery showed by consumers who were fully responsible towards self, may confirm the importance of Responsibility as one of the 10 fundamental components of Recovery⁴⁷.

There were significant correlations between (HRQ_6) and CLAS subscales. This result achieved our subsidiary objective which was to put a step in the

construction and the standardization of Human Rights of persons with psychosocial and mental disability attitude questionnaire (HRQ_6).

In sum, this study represents one of the first to explore the attitudes of staff and consumers toward human rights of persons with psychosocial and mental disabilities and their integration into the community in Sudan and in the region.

This study revealed the huge gap in human rights training in mental health field coupled with lack of knowledge regarding recovery oriented mental health services.

The past era of medical model of disability dominating the picture in mental health services in Sudan, therefore the general theme of thinking in this study was in line with this fact. Training and knowledge can make the difference in favor of social model of disability is supported by the following:

- Staff attitudes toward human rights of persons with psychosocial and mental disabilities were much better than the consumers.
- Among the staff doctors had more positive attitudes toward human rights of persons with psychosocial and mental disabilities than other staff members in mental health field. Therefore with suitable training they can lead the reform in mental health services.

2.4.2. Limitations of this study:

Several considerations recommend some caution in interpreting these findings. First, Although HRQ_6 is based on conventions on the rights of persons with disability, still is not standardized tool to assess attitudes towards human rights of persons with psychosocial and mental disabilities. Also the CLAS has not previously been used with a Sudanese sample.

Second, all the problems of translation were there when we translated CLAS and HRQ_6 and will still remain beside the influence of cultural factors, so some concepts might not be accurately identical due to cultural factors.

Third, comparison groups from the same culture and background were not available due to lack of studies in this area.

Fourth, the participants may not be very accurate in answering the questionnaires.

Fifth, the sample is a convenient sample, so bias results and misrepresentation of data are expected to some extent.

Finally, some factors in this study could influence the effect of each other. e.g., most of the nurses had lower educational level than the other professional groups and were working for more than 10 years in the field of mental health.

2.5. CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

Chapter 5 - Conclusion and Recommendations

2.5.1. Conclusion

In sum, in this study, we attempted to examine the attitude of staff and consumers toward human rights of persons with mental health problems and the differences between the two groups. The results in general showed negative attitude of both groups consistent with background of human rights issues in our community. Still there were significant differences between the two groups with the staff had more positive attitude than the consumers. The differences in attitudes among the staff were mainly a result of their education and professional role. Most of the staff had been educated on the medical model, and their beliefs still retained some of the barriers.

The practical application of the convention on rights of persons with disabilities (CRPD) in mental health field still is far away especially in low income countries!

This study represents one of the first to explore staff and consumers' attitudes towards human rights of persons with mental health problems. It is hoped that this work will highlight human rights training gap in mental health field as well as in our community.

All the stakeholders in mental health field should be committed to respecting all human rights of the consumers including their rights of inclusion into the community.

The concept of recovery oriented mental practice among both groups not well formed yet.

Finally, this study demonstrates that human rights' training in mental health services is not a priority in Sudan.

2.5.2. Recommendations

- i. Protection of Human rights is the back bone of the effective mental health services. Based on the result of this study, stakeholders in mental health in Sudan should design effective programmes with adequate time for human rights training throughout all mental health programs in Sudan.
- ii. Still there are many areas to explore within the field of human rights when addressing mental health services in Sudan. The WHO QualityRights tool kit can be used to assess quality of mental health services in Sudan.
- iii. Grassroots advocates are needed to raise the level of awareness regarding human rights of persons with psychosocial and mental disability in our community and among mental health care providers.
- iv. There is a need for further research on the attitudes towards rights of persons with mental health problem among public groups, community leaders, faith healers, non-psychiatric health care providers and other stakeholders in mental health field.
- v. There is urgent need for mental health policies and laws in Sudan to improve conditions for people with mental disabilities.
- vi. Community-based services and supports as alternatives to institutional care should be adopted by stakeholders in mental health services.

2.6. CHAPTER SIX: REFERENCES

CHAPTER 6 - REFERENCES

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Appendix

The International Master in Mental Health Policy and Services

Nova Medical School

New University of Lisbon

Portugal

Questionnaire to assess the Attitudes of Staff and Consumers toward Human Rights of Persons with Psychosocial and Mental Disabilities (consumers)

Dr. Abdelaziz Osman carries out this study as a final year project of the International Master of Mental Health Policy and Services, the University of New Lisbon, Portugal.

The aim of the study is to assess the attitude toward human rights of person with psychosocial and mental disabilities, to recommend the types of training required in this area in order to improve mental health services in our country and region. We appreciate so much your participation in this study.

Identity will be anonymous and information will be used for research purposes only.

Kindly, fill the following questions: (put a √).

Filling in the questionnaire takes about 15 minutes.

Please read the instructions, before filling in the questionnaire, read each question, including the answering options, before giving an answer, choose the answer that is most applicable to your situation, and choose only one answer, unless stated differently.

Please fill in this questionnaire only for yourself and your situation.

The questionnaire will be collected by our team during normal working hours.

Feel free to withdraw from the study at any part of the procedure.

Feel free to contact Dr. Abdelaziz at this email address wedetman@yahoo.com or azzaww@gmail.com.

1. Hospital Elmahi <input type="checkbox"/> Baesher <input type="checkbox"/> Elidreisi <input type="checkbox"/>	2. Gender Male <input type="checkbox"/> Female <input type="checkbox"/> No answer <input type="checkbox"/>	3. Marital status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/>	4. Age (years) <input type="text"/>	5. Level of education Illiterate <input type="checkbox"/> Under graduate <input type="checkbox"/> Graduate and post graduate <input type="checkbox"/>
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6. Employment: Unemployed ☐ Student ☐ Laborer ☐ Technician ☐ Officer ☐ Professional ☐
Merchant ☐ Other ☐

7. Do you have children? Yes ☐ No ☐ if yes no. ☐

8. The responsibility towards yourself:

Fully by self ☐ partially by self (with the assistance of others) ☐ fully by others ☐

9. Are there any people such as children, the mother and father or others under your direct responsibility?

Yes ☐ No ☐

10. Numbers of years with mental illness: less than 5 ☐ 5 to 10 ☐ more than 10 ☐

11. Have you received any training on human rights? Yes ☐ No ☐

12. What do you think about Recovery from mental illness?

Is attainable for everyone ☐ Is attainable for some people ☐ Is not attainable at all ☐

Following are a couple of statements about the rights of persons with mental disabilities. We would like to know whether you agree with the statement or not and in what degree. If you do not have a strong opinion, please try to find out if it is more like 'agree or more like 'disagree. If you really do not know, you can select one of the two options "somewhat disagree or somewhat agree", that you are comfortable with.

13. In Sudan no need for mental health legislation to protect the rights of persons with psychosocial and mental disabilities.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

14. All nations should work toward liberty and justice for all including persons with psychosocial and mental disabilities.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

15. Persons with psychosocial and mental disabilities should be able to have a voice in how they deal with their own physical well-being, with their health and with their illnesses.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

16. Persons with psychosocial and mental disabilities should be able to lead, control, exercise choice over, and determine their own path of recovery.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

17. Occasionally it is reasonable to deny the right to vote to some groups of persons with psychosocial and mental disabilities; for instance to persons with sever types of schizophrenia.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

18. Teenagers with psychosocial and mental disability should be allowed to receive all types of medical and psychosocial treatments without parental consent.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

19. It is legitimate for authorities to curtail the activities of persons with psychosocial and mental disabilities which are socially unacceptable; for instance wandering along the street with dirty clothes.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

20. All citizens should be given full constitutional rights but citizens with psychosocial and mental disabilities should not expect to be given all those rights.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

21. Persons with psychosocial and mental disabilities should not have to worry about unwarranted intrusions by the government, family and friends into their private lives.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

22. Books should be banned if they are written by persons with psychosocial and mental disabilities who have been in acute psychotic state during the time of writing.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

23. Police should not have to get search warrants when they are pursuing suspects with known severe mental illness.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

24. Discrimination against because of psychosocial and mental disability is justifiable sometimes.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
25. We should not waste time to support persons with psychosocial or mental disabilities to take their decisions about self, when we are 100% sure they are not able to make decisions.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
26. Persons with psychosocial and mental disabilities should have the right to involve the traditional healers in their management plan.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
27. Persons with psychosocial and mental disabilities probably shouldn't be hired for jobs requiring considerable contact with the public since they could behave in a strange way.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
28. As soon as a person shows signs of mental disturbance, he should be hospitalized.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
29. Counselors should encourage persons with psychosocial and mental disabilities to consider training to become doctors, pilots, carpenters, military officers and other occupations that fit with their potentials regardless to their illness.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
30. For persons with psychosocial and mental disabilities is better to give welfare assistance rather than to encourage employment in order to protect them
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
31. Freedom of speech should be a basic human right except for persons with psychosocial and mental disabilities because they can embarrass their families and friends.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
32. The environment should be adapted to the needs of persons with psychosocial and mental disabilities even if doing so is expensive.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
33. The Convention on the Rights of Persons with Disabilities (CRPD) could disrupt society with its emphasis on treating persons with psychosocial and mental disabilities like others.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
34. Teachers with psychosocial and mental disabilities can be good role models for our children, just like anyone else.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐
35. Publishers, speakers, professionals and others since they are not intending stigma can use stigmatizing terms such as psychotic, schizophrenic and demented instead of usual terms such as persons with psychosis, with schizophrenia and with dementia.
Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

36. Persons with psychosocial and mental disabilities should enjoy legal capacity on an equal basis with others in all aspects of life.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

37. Persons with psychosocial and mental disabilities should not be deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

38. Persons with psychosocial and mental disabilities should not be allowed to marry and have children

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

39. A person would be foolish to marry a person with psychosocial and mental Disability

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

40. Persons with psychosocial and mental disabilities can plan meetings and conferences without assistance from others.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

41. Persons with psychosocial and mental disabilities can be trusted to handle money responsibly.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

42. The opinion of a person with psychosocial and mental disability should carry more weight than those of family members and professionals in decisions affecting that person.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

43. Sheltered workshops for persons with psychosocial and mental disabilities are essential.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

44. Increased spending on programs for persons with psychosocial and mental disabilities is a waste of tax dollars.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

45. Homes and services for persons with psychosocial and mental disabilities downgrade the neighborhoods they are in.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

46. Persons with psychosocial and mental disabilities are a burden to society.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

47. Homes and services for persons with psychosocial and mental disabilities should be kept out of residential neighborhoods.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

48. Persons with psychosocial and mental disabilities need someone to plan their activities for them.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

49. Persons with psychosocial and mental disabilities do not need to make choices about the things they will do each day.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

50. Persons with psychosocial and mental disabilities can be productive members of society.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐ 51. Persons with psychosocial and mental disabilities have goals for their lives like other people.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree.

52. Persons with psychosocial and mental disabilities can have close personal relationships just like everyone else

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐ 53. Persons with psychosocial and mental disabilities should live in sheltered facilities because of the danger of life in the community.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐ 54. Persons with psychosocial and mental disabilities usually should be in group homes or other facilities where they can have the help and support of staff.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

Glossary

Convention on Rights of Persons with Disabilities (CRPD): is an international human rights treaty of the United Nations. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law.

Recovery: Recovery in mental health is to regain meaningful life in spite of serious mental illness

Mental health legislation: In Sudan, currently a new version of mental health act is ready for implementation. The last version dates back to 1998

Sheltered workshops: refers to an organization or environment that employs people with disabilities separately from others.

The International Master in Mental Health Policy and Services

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Questionnaire to assess the Attitudes of Staff and Consumers toward Human Rights of Persons with Psychosocial and Mental Disabilities (Staff)

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The aim of the study is to assess the attitude toward human rights of person with psychosocial and mental disabilities, to recommend the types of training required in this area in order to improve mental health services in our country and region. We appreciate so much your participation in this study.

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2. Hospital Elmahi <input type="checkbox"/> Baesher <input type="checkbox"/> Elidreisi <input type="checkbox"/>	2. Gender Male <input type="checkbox"/> Female <input type="checkbox"/> No answer <input type="checkbox"/>	3. Marital status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/>	4. Age (years) <input type="text"/>	5. Current professional job Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Psychologist <input type="checkbox"/> Social worker <input type="checkbox"/>
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6. Last degree: Diploma ☐ Bachelor ☐ Post graduation studies in mental health field ☐

7. Have you experienced yourself any psychosocial or mental troubles/problems? Yes ☐ No ☐

8. Have you directly experienced any psychosocial or mental troubles/problems with one of your relatives/close friends? Yes ☐ No ☐

9. Did you have any contact to a mental health services as a user? Yes ☐ No ☐

10. Numbers of years working in Mental Health: less than 5 ☐ 5 to 10 ☐ more than 10 ☐

11. What do you think about Recovery from mental illness?

Is attainable for everyone ☐ Is attainable for some people ☐ Is not attainable at all ☐

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43. Sheltered workshops for persons with psychosocial and mental disabilities are essential.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

44. Increased spending on programs for persons with psychosocial and mental disabilities is a waste of tax dollars.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

45. Homes and services for persons with psychosocial and mental disabilities downgrade the neighborhoods they are in.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

46. Persons with psychosocial and mental disabilities are a burden to society.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

47. Homes and services for persons with psychosocial and mental disabilities should be kept out of residential neighborhoods.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

48. Persons with psychosocial and mental disabilities need someone to plan their activities for them.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

49. Persons with psychosocial and mental disabilities do not need to make choices about the things they will do each day.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

50. Persons with psychosocial and mental disabilities can be productive members of society.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

51. Persons with psychosocial and mental disabilities have goals for their lives like other people.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

52. Persons with psychosocial and mental disabilities can have close personal relationships just like everyone else.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

53. Persons with psychosocial and mental disabilities should live in sheltered facilities because of the danger of life in the community.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

54. Persons with psychosocial and mental disabilities usually should be in group homes or other facilities where they can have the help and support of staff.

Strongly disagree. ☐ Disagree. ☐ Somewhat disagree. ☐ Somewhat agree. ☐ Agree. ☐ Strongly agree ☐

Glossary

Convention on Rights of Persons with Disabilities (CRPD): is an international human rights treaty of the United Nations. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law.

Recovery: Recovery in mental health is to regain meaningful life in spite of serious mental illness

Mental health legislation: In Sudan, currently a new version of mental health act is ready for implementation. The last version dates back to 1998

Sheltered workshops: refers to an organization or environment that employs people with disabilities separately from others.